The Contribution of Nurse, Midwife and Health Visitor Entrepreneurs to Patient Choice: A scoping exercise

A report to the National Co-ordinating Centre for NHS Service Delivery and Organisation

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Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

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Executive Summary

Introduction and methods

This scoping exercise had the following aims. To:

- Develop definitions of nurse midwife and health visitor (NMHV) entrepreneurship in relation to current definitions of patient choice.
- Map the range and types of entrepreneurial NMHV activity across primary, secondary and tertiary health and social care provision in the state- and independently provided sectors in the UK and related fields, and to map policy initiatives in this area.
- Conduct a review of available international published and grey literature concerning models of entrepreneurship in health care and related fields and identify NMHV activity and policy initiatives in this area.
- Analyse the extent of the evidence at a policy and local delivery level of both drivers and inhibitors of entrepreneurial activity by NMHVs, in particular relating to the patient choice agenda and current NHS policy concerning contractual freedoms.
- Use these sources to identify any design and delivery issues relevant to NMHV entrepreneurship that might promote better outcomes, including choice for patients, carers and their families.
- Identify gaps in current knowledge and elaborate key research questions in order to inform future NHS Service Delivery and Organisation Research and Development calls for proposals.

There were five elements to our scoping:

1. Exploring understandings of the use of the terms ‘entrepreneur’ and ‘entrepreneurial’.
3. Expert seminars with NMHV entrepreneurs and those responsible for commissioning such services or making policy with relevance to them.
4. Mapping and analysis of relevant policy over a 10-year period, including policy concerning patient choice.
5. Synthesis of evidence and identification of gaps in knowledge and formulation of questions for further research.
Setting the entrepreneurial scene

One seminal definition of an entrepreneur is ‘one who shifts economic resources out of an area of lower and into an area of higher productivity and greater yield’. The mid 1980s saw the introduction of the term ‘intrapreneur’ to describe an employee who behaves ‘entrepreneurially’ within a corporation. The term ‘social entrepreneur’ has developed to describe those individuals who apply the same enterprise and imagination to social problems that commercial entrepreneurs apply to wealth creation. Social entrepreneurialism has been seen as an appropriate model for developing NMHV entrepreneurial activity. The term has been taken up by the UK government as part of its programme to address social inequality. One of the criticisms of much of the entrepreneurial literature is that it has focused on men involved in activities associated with financial gain rather than social objectives. This does not reflect either the purpose or the gender profile of nursing in the UK, where 89% of registered NMHVs are female. Globally, women are increasingly engaging in entrepreneurial activity and they tend to report different drivers and barriers to becoming entrepreneurs to men.

The policy context

Government policy has attempted to promote aspects of entrepreneurial behaviour as one element of its approach to addressing social problems such as inequality and exclusion and to add flexibility to some health and social services traditionally delivered by state agencies. Health policy, since 1997 has featured ‘modernisation’ and, increasingly, patient choice. Some policy documents, such as The NHS Plan: A plan for investment, a plan for reform (Department of Health, 2000) and Making a difference: Strengthening the nursing, midwifery and health visiting contribution to health and healthcare (Department of Health, 1999a), set out changes that are said to ‘put nurses at the heart of the modernisation agenda’. Later messages have explicitly urged nurses to become ‘entrepreneurs’, though the examples given of such entrepreneurial behaviour are limited and often only involve medical role substitution. The term ‘entrepreneur’ has been used loosely. Successive changes to commissioning in the primary care sector have encouraged a wider range of providers. This has opened up the possibility – and the reality in a very small number of cases – for services to be provided by nurse-owned or -led enterprises.
Nurses, midwives, health visitors and entrepreneurship: The evidence

There is very little research literature on NMHV entrepreneurial activity and personal, ‘heroic’ and journalist-written accounts dominate. Of 462 articles initially identified from our electronic and hand searches, 143 met the inclusion criteria of relevance to the scoping. A total of 104 published papers described entrepreneurial activities of UK NMHVs. Beyond this was an additional grey literature, e.g. we found 119 articles dealing with UK entrepreneurial activity among NMHVs in primary care settings alone. The International Council of Nursing estimates that, in general, 0.5–1% of registered practising nurses are nurse entrepreneurs. The following typology was developed from the literature:

- **The NMHV entrepreneurial employees (intrapreneurs):** NMHVs in quasi-autonomous public health roles; NMHVs in clinical specialist roles
- **Employers/self-employed providers of services with an indirect relationship to health care:** Nurse consultancies; infrastructure and workforce providers; inventors/manufacturers
- **Employers/self-employed providers of direct health care services:** Mainstream health services delivered through the NHS; NMHV services offered directly to clients; other health-related services provided by NMHVs directly to a client; accommodation with nursing and health-related services provided by NMHV proprietors.

Findings from the expert seminars

The expert seminars were attended by 18 people. The discussions revealed information not apparent from the literature, and these points are incorporated in our summary of findings.

Summary of findings

Although we found a range of NMHV entrepreneurial activity in the UK, it represents only a very small proportion of NMHVs and former NMHVs engaged in these types of activities. In this, it reflects most of the international literature.

There is only modest agreement over the meaning of the term ‘entrepreneur’ in business and management literature. This does not help an understanding of the term ‘nurse entrepreneur’. In some UK policy articulations, the term ‘nurse entrepreneur’ is used loosely, is
ideological and the actual examples given are often more accurately
described as organisational flexibility or nurse substitution for medical
roles.

The international literature on nurse entrepreneurs uses the term
‘entrepreneurial’ interchangeably with ‘enterprise’ in some countries or
uses completely different terms to describe self-employed nurses and
midwives or business owners (see Sections 2 and 4).

The scoping took a broad view of definitions in order to include rather
than exclude activities (Sections 1 and 2). However, there were
challenges in dealing with the overlap with literature on innovation
and change (Sections 1 and 4).

The UK scoping was analysed by type of activity (Section 4.4). It was
noted that certain groups of NMHVs, such as those with public health
roles or some clinical specialist roles, are more likely to be
intrapreneural. Entrepreneurial NMHV activities were identified that
indirectly contribute to health care, such as knowledge transfer
through training and consultancy, invention of health care products,
and provision of infrastructure services to health care, in addition to
provision of direct health care services by self-employed and small
business (Section 4.4.4).

Some recent policy changes relating to commissioning in the NHS
primary care sector and the creation of a supply-side market through
encouraging ‘third-sector’ health and social care enterprises, make
new forms of NMHV entrepreneurial and business activity possible.
Section 4 documents the limited extent of this type of activity by
NMHVs at present, although in a rapidly changing policy and policy
implementation environment there is potential for this picture to shift.
It is not clear to what extent NMHVs will move from being employees
of the NHS or general practice to being nascent entrepreneurs as
employers in new types of social enterprise business or as business
partners in general practice. Nor is it clear how nascent NMHV
entrepreneurs will fare when competing for contracts in environments
where many more entrepreneurs and businesses are established,
including large corporations, who are becoming involved in tendering
for these new business opportunities.

It is noteworthy that many NMHV entrepreneurs had close
relationships with the NHS. For some this was the source of their
business, while others reverted to temporary employment when
income levels dropped, moving out again because of dissatisfaction
with the constraints of the NHS, and moving back in when self-
employment was precarious.

We are uncertain whether increased levels of NMHV entrepreneurial
activity are likely in the future. The expert seminars tended to indicate
that those NMHVs who have left the NHS to set up in business on their
own, in a largely hostile and unfavourable climate, are atypical of the
NMHV workforce as a whole. As these are classic characteristics
associated with entrepreneurs, this may be unsurprising, but their atypicality raises questions about the likelihood of increased numbers of NMHVs behaving entrepreneurially in this sector, which future research would need to explore.

The connection between NMHV entrepreneurial activity and patient choice appears not to be strong (Section 4.6), with the possible exception of independent midwifery. Increasing patient choice was stated as an aspiration in 20% of the documents we analysed. Aspirations concerning autonomy of practice and professional accomplishment were cited in approximately 55% of these documents. Financial motivations are not prominent in the literature, but our seminar participants suggested that this might be a misconception, arising because talk of the profit motive is perceived as unacceptable within NMHV culture. The documented aspirations of the sample of intrapreneurial NMHVs were focused on addressing issues of equity in provision and access for those poorly served by current arrangements.

There is very little actual measurement (and therefore evidence) of the outcomes of entrepreneurial activity (Section 4.6.1). If entrepreneurialism is an area to be encouraged, good process and outcome evaluations are needed to identify what works.

The theme of choice has a longer history in midwifery, with policy in the early 1990s encouraging choice for women in childbirth. However, increased choice is confined to a small number of clients, geographical access is restricted and user fees currently allow choice only for those who can afford to pay.

Both the literature and our expert seminars revealed some of the obstacles to becoming entrepreneurial and surviving successfully in those roles. These obstacles included the importance of the wider context – the NHS in general, its present state of flux and the wider professional environment – as both NMHV socialisation and NMHV work take place within the overarching power structures of the health sector. If the NHS itself changes (e.g. becomes less secure and supportive), then the balancing of risk/safety and cost/benefit of staying in the organisation versus leaving to become an entrepreneur will also change.
## Definitions of terms and assumptions

<table>
<thead>
<tr>
<th>Term/assumption</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>Any member of the population receiving care</td>
</tr>
<tr>
<td>Patient choice</td>
<td>We adopt a broad understanding to include choice over how to access health care services, where to access them and which type of worker to access them through</td>
</tr>
<tr>
<td>NMHV</td>
<td>Nurses, midwives and health visitors (see Appendix 1 for more information about the characteristics of the UK NMHV workforce)</td>
</tr>
<tr>
<td>Nurse, midwife and health visitor entrepreneur</td>
<td>Those NMHV entrepreneurs involved in health-related activities (rather than activities with no connection to health or health care)</td>
</tr>
<tr>
<td>Innovation and entrepreneurialism</td>
<td>The boundary between innovation and entrepreneurialism is not distinct. Our operational differentiation is found in the in Section 1</td>
</tr>
<tr>
<td>Drivers</td>
<td>Broader forces encouraging entrepreneurial activity</td>
</tr>
<tr>
<td>Intrapreneurialism</td>
<td>Entrepreneurial activity within an organisation to reinvigorate established businesses</td>
</tr>
<tr>
<td>Triggers</td>
<td>A specific event or circumstance that an individual describes as tipping their decision to become and entrepreneur</td>
</tr>
<tr>
<td>Our policy cut-off point for this scoping</td>
<td>March 2006</td>
</tr>
</tbody>
</table>
The Report

Section 1  Introduction and methods

1.1 Background and project aims

This document is a report of the scoping exercise commissioned by the National Co-ordinating Centre for NHS Service Delivery and Organisation Research and Development (NCCSDO) concerning the extent and character of nurse, midwife and health visitor (NMHV) entrepreneurial activity and its relationship to patient choice.

In this section we set out the aims of this project and detail the methods of the different aspects of our scoping.

This scoping exercise had the following aims:

- Develop definitions of NMHV entrepreneurship in relation to current definitions of patient choice.
- Map the range and types of NMHV entrepreneurial activity across primary, secondary and tertiary health and social care provision in the state and independently provided sectors in the UK.
- Conduct a review of available international published and grey literature concerning models of entrepreneurship in health care and related fields and identify NMHV activity and policy initiatives in this area.
- Analyse the extent of the evidence at a policy and local delivery level of both drivers and inhibitors of entrepreneurial activity by NMHVs, in particular related to the patient choice agenda and current NHS policy concerning contractual freedoms.
- Use these sources to identify any design and delivery issues relevant to NMHV entrepreneurship that might promote better outcomes, including choice for patients, carers and their families.
- Identify gaps in current knowledge and elaborate key research questions in order to inform future NCCSDO calls for proposals.

There were five elements to our scoping:

1. Exploring understandings of the use of the terms ‘entrepreneur’ and ‘entrepreneurial’.
2. A review of the published and grey literature for NMHV entrepreneurial activity, research and issues. Relevant literature was identified via: electronic and hand searching; electronic scoping through e-lists (e.g. the Contacts, Help, Information and Advice Network [CHAIN] and the Primary Care Research
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Network); senior nurses involved in commissioning; web searches for examples of UK nurse entrepreneurship.

3 Expert seminars.

4 Policy mapping and analysis (including analysis of patient choice).

5 Synthesis of evidence and identification of gaps in knowledge.

1.2 Outline of the report

Our approach and findings are summarised in the short executive summary. Section 1 describes the five main methods of investigation and analysis that we adopted and explains how we categorised the available literature. Section 2 gives an account of the varied and changing use of key terms around entrepreneurialism (e.g. intrapreneurialism and social entrepreneurialism) within the literature from business, management, social policy and psychological fields, and goes on to present literature about women entrepreneurs. Section 3 provides an analysis of NHS and other policy concerning overarching NHS priorities, the encouragement and enabling of contractual freedoms, the encouragement of innovative and entrepreneurial activity in nursing, midwifery and health visiting and patient choice. Section 4 provides a thorough and substantive map of the available literature (both theoretical, e.g. a categorisation of commissioning and financing of health care services, and empirical). It includes a discussion of the quality of the literature surveyed, a description of the process of categorisation and the creation of a typology for entrepreneurial activity and the identification of the volume in each category by source of information (e.g. literature, e-scoping) and by sector. Analysis by categories and sectors of geographical spread, financial information and stated drivers and inhibitors, aspirational claims and the extent and character of any evaluations are included. Section 5 presents the findings of the expert seminars that we ran for nurse entrepreneurs and others. Section 6 summarises what we have learnt from the scoping exercise and identifies gaps in current knowledge and proposes areas for further research and how they might be addressed, including primary research. It sets out the relevance for NHS policy of such subsequent work and identifies the limitations of the study. Finally, the appendices set out the bibliographic and other reference materials that were identified during the study.

1.3 The method of enquiry

The function of a scoping review is ‘to map rapidly the key concepts underpinning a research area and the main resources and types of evidence available’ (Mays et al., 2001). A mixed-method scoping approach was used for the current exercise. The elements are listed in Section 1.1 and are detailed in Sections 1.3.1–1.3.5.
1.3.1 Exploring understandings of the use of the terms entrepreneur and entrepreneurial

This involved a search through the major literature on these topics from business, management, social policy and psychology. There were no formal inclusion criteria for this wide-ranging review, as early discussions of the character of entrepreneurs date from the early 18th century and the type of literature in which such discussions occur is broad in nature and global in scope. We reviewed literature discussing the character of entrepreneurialism, entrepreneurs and various related concepts. The literature on women as entrepreneurs was drawn from similarly wide and global sources in order to provide context for an understanding of NMHVs as entrepreneurs.

1.3.2 Review of published and grey literature

Electronic searches of databases

Bibliographic databases included: MEDLINE®, CINAHL®, EMBASE™, Allied and Complementary Medicine Database (AMED), Midwives Information and Resource Service (MIDIRS), British Nursing Index, Health Management Information Consortium (HMIC), DH-Data (Department of Health), the Cochrane Library (including the Health Technology Assessment database), Web of Science (Social Science Citation Index), SIGLE (System for Information on Grey literature in Europe), Index to Theses, PsycINFO®, Social Care Online and the National Research Register. The search also covered the EBSCO full-text collection of journals and a manual search of the King’s Fund Library database.

Single and combined search terms, determined at an early meeting of team members, were used and initially included: ‘entrepreneur$’, ‘business’, ‘private practice’, ‘self-employ$’, ‘intrapreneur$’ and ‘social capital’; these terms were related to a second layer of terms ‘Nurs$’, ‘Midwi$’, ‘Visit$’, ‘Entrepreneur$’. Additional terms were added in light of the low yield and after further discussion among the research team. These were ‘social enterprise$', ‘mutuals’, ‘collectives’, ‘co-op’, ‘Private Midwi$’, ‘Independent Midwi$’ and ‘nursing workforce$. The above terms were used to search free text and subject headings. Free text searches are more inclusive as they pick up both body text and subject headings.

A third layer of search terms was used in a search of subject headings to explore the contribution of NMHV entrepreneurship to patient choice. These terms were ‘patient choice’, ‘patient autonomy’, ‘patient decision-making’, ‘patient or health services accessibility’ and ‘health services needs and demands’. These terms were not necessarily combined with the terms in both of the first two layers because we were looking for extra literature that did not necessarily contain all three concepts. We used these ‘third-layer’ terms in combination with either of the first two layers. The number of additional publications
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identified in this way was very small (n=9). Although there is a considerable volume of literature on 'patient choice' (e.g. Fotaki et al., 2005), the only documents from this initial trawl linking NMHV 'entrepreneurship' with 'patient choice' were found in the midwifery literature. We considered undertaking a citation search of 6–8 key articles to track their influence, but the literature was such that no such key articles could be identified. Subsequent searches focused on the primary care sector and on midwifery because these were areas where existing evidence would suggest that the great majority of NMHV entrepreneurial activity is occurring (see Section 3 on policy drivers).

Electronic scoping through e-list networks

This is a fast-moving field and it was recognised that there might be new or different activities that had not yet featured in published articles in mainstream journals. We thus made requests through UK online e-group networks for any additional published/grey literature relating to entrepreneurial activities among NMHVs. Eight e-group networks were contacted and an email was distributed to them (Appendix 2). These groups were; CHAIN (CHAIN 1, 140 members), Nurse UK list (163 members), Primary Care Nursing Research Network (100 members), Practice Nurse network (number unknown), HV-School Nurse forum (90 members), Royal College of Nursing (RCN) Nurse Entrepreneurs Forum (a subgroup of the Independent Nurse Managers Forum; 300 members), Consultant Midwives e-group on Yahoo, Midwifery Research JISCmail and the RCN Research and Development network (distributed UK-wide, numbers unknown).

The electronic scoping resulted in 38 responses.

Hand searching and additional searches for grey literature

To enhance the search for publications and to identify additional relevant papers, articles and reports, we also hand searched (mainly at the King’s Fund and Royal College of Nursing libraries in London) a range of speciality-related journals/magazines: Community Practitioner (1998 Volume 71 to present), Journal of Community Nursing (1996 Volume 10 to present), Independent Nurse (2005 to present) and Primary Health Care (2000 Volume 10 to present). Three significant oncology nursing publications were also hand searched: the European Journal of Oncology Nursing, Cancer Nursing and the Journal of Clinical Oncology (1996–2005). We chose the speciality of oncology as an exemplar of the acute sector because we considered that it would provide the richest seam of entrepreneurial activity. There may be other activity in other specialities. In addition, we investigated articles and news items available from a range of world wide web online sources (Appendix 4).

Details of all documents identified were managed in a bibliographic management package (Reference Manager). Abstracts and reports
from journalists, databases and hand-searched reference lists were assessed for relevance to the topic of the scoping exercise. An inclusive approach to the thematic documents was used, as the purpose was to uncover and describe current knowledge of the activities and behaviours of NMHVs involved in any aspects of entrepreneurialism. The focus of the search was UK based, but international literature providing comparative examples was also identified.

Identification and assessment of the core documents

The assessment of the literature and other documentation proceeded in three stages. In the first stage, published articles identified through the database search were sorted chronologically by publication date (from 1996 to the present) in order to identify trends and policy changes over time that might be specific to NMHVs’ entrepreneurial behaviours or activities. At this point, it became clear that the category of ‘intrapreneurial’ activity (entrepreneurial activity within an organisation to reinvigorate established businesses) had very ‘fuzzy’ boundaries. Considerable overlap was found in the health care sphere between intrapreneurial activities and other current concepts such as ‘leadership’ and ‘innovation’. Hence the search into intrapreneurial activity has not produced a definitive publications list. So while intrapreneurship is recognised in this review as part of the spectrum of entrepreneurial activity (see Section 2), it was not possible to set clearly defined boundaries that would permit identification of a clear literature sub-set for NMHV intrapreneurship as a whole. Instead, examples of ‘intrapreneurial’ activity are employed in the review to highlight the intra-institutional end of the entrepreneurial spectrum of activity, for example key papers on ‘one-to-one’ or ‘case loading’ midwifery within the NHS. This first stage resulted in 462 papers being identified, of which 143 met the inclusion criteria.

The second stage involved quantifying the papers according to continent of origin. The core focus for the scoping exercise was UK literature and this was the criterion used for inclusion in the literature analysis (Table 1). Articles from the international literature have been included when they contain empirical research from which lessons relevant to the UK can be learned. For example, articles from countries where independent contractor models in nursing, midwifery or health visiting are more widely practised than in the UK, such as independent midwifery in New Zealand. The amount of literature worldwide does not necessarily represent the amount of actual activity.

At the third stage, the UK papers were allocated into one of six broad categories of documentation:

- Empirical research paper
- Theoretical ‘think piece’ (describing a model, theory or framework)
Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

- Opinion piece (professional, views, thoughts, exertions)
- Personal narrative (practitioner and user descriptions of working practice providing primary evidence of an activity)
- Journalist feature article (of an entrepreneurial initiative/activity)
- Brief news item.

**Table 1** Published papers specific to UK entrepreneurial activity among NMHVs

<table>
<thead>
<tr>
<th>Literature type</th>
<th>No. of papers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empirical research paper</td>
<td>13</td>
</tr>
<tr>
<td>Theoretical or academic paper</td>
<td>13</td>
</tr>
<tr>
<td>Opinion piece</td>
<td>21</td>
</tr>
<tr>
<td>Personal narratives</td>
<td>31</td>
</tr>
<tr>
<td>Journalist feature article</td>
<td>19</td>
</tr>
<tr>
<td>Brief news items</td>
<td>5</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>104</strong></td>
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</tbody>
</table>

Beyond this literature is a large body of unpublished or locally published material. Table 2 is included as a non-exhaustive example of the grey literature available within the primary care field alone. It shows the balance of the types of literature that are extant and is indicative of the field as a whole.

**Table 2** Grey literature specific to nurses and health visitors working in primary care settings in the UK

<table>
<thead>
<tr>
<th>Literature type</th>
<th>No. of papers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empirical research paper</td>
<td>4</td>
</tr>
<tr>
<td>Theoretical or academic paper</td>
<td>0</td>
</tr>
<tr>
<td>Opinion piece</td>
<td>12</td>
</tr>
<tr>
<td>Personal narratives</td>
<td>21</td>
</tr>
<tr>
<td>Journalist feature article</td>
<td>36</td>
</tr>
<tr>
<td>Brief news items</td>
<td>46</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>119</strong></td>
</tr>
</tbody>
</table>
1.3.3 Expert seminars

The seminars followed on from the comprehensive literature searches and were intended to test and refine the understanding of entrepreneurial activity in practice through discussion of our findings with key stakeholders working in the field. In the seminars, we invited participants to draw on their own experience to provide feedback on our definitions of entrepreneurial practice and on our findings with regard to the breadth of such activity and the drivers and inhibitors of its development. We also explored participants’ views of the intended and actual impacts of entrepreneurial activity, particularly its contribution to patient choice. Throughout the discussions participants were invited to flag up further sources of literature and examples of good practice.

Seminar participants

The seminars were designed to bring together small groups of stakeholders with different expertise and knowledge of nursing, midwifery and health visiting entrepreneurial activity in health care gained through their experience as providers, commissioners, service users and consultants working at local and national levels. For this purpose, ‘users’ were defined as representatives from charities or user groups rather than individual users. Stakeholders from each of these groups were identified from the literature searches and from contacts known to members of the research team.

Participants were invited to the seminars by an email (Appendix 2) with an accompanying letter that provided detailed information about the aims and context of the study. Overall, 49 people were approached and many of these expressed considerable interest in participating in the study. However, because of the tight timescale for the project, which meant that seminar dates had to be fixed before inviting potential participants, many of those initially approached were already otherwise engaged. Where people who had been invited were unable to attend, we asked for and followed up their suggestions for alternative individuals. We followed up separately with two of the individuals unable to attend the seminars to ask them about their views on the subjects covered in the seminar. The initial intention was to run three seminars, but one of these had to be cancelled, as too few participants were able to attend on the date selected. The two seminars took place in April 2006.

The names and job titles of the 18 people who participated are listed in Appendix 3, along with the members of the research team who attended the sessions. In the second seminar one participant cancelled at the last minute and another did not turn up. They were subsequently contacted by phone to ask their views on the subjects covered in the seminar. A wide range of interests was represented at the seminars; unfortunately there was less representation from user groups than was hoped for, although six such groups were invited.
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**Seminar format**

In advance of each seminar, participants were sent a copy of a briefing paper that explained how we had approached the task so far and which raised some issues relating to entrepreneurship to provide a stimulus for thinking in advance of the seminar discussion. The paper outlined the preliminary findings on the various types of entrepreneur and an initial analysis of the inhibitors and drivers of entrepreneurial practice.

Each seminar was attended by members of the research team who began by outlining the purpose of the study, before sharing the preliminary findings of the research in two presentations, and then facilitating the discussion. The first presentation reported the preliminary findings on the current scope and nature of entrepreneurial activity in nursing, midwifery and health visiting. This was followed by a facilitated discussion exploring participants’ perceptions of the factors that shape, enable and constrain entrepreneurial activities in this field. The second presentation covered the aims and impacts of the various entrepreneurial activities identified in the scoping review. This was followed by a facilitated discussion about the potential impacts of these activities, including the effects on patient choice.

The objective of the sessions was to have a free-ranging discussion and we did not necessarily aim to achieve consensus among the participants. In order to encourage open expression of views, it was agreed that the Chatham House Rule would apply, i.e. there was confidentiality within the group and that anything that was reported would be done so without attribution. Ethical clearance was obtained via the Central Office for Research Ethics Committees before the seminars took place and participants gave signed consent to their participation. Each participant was asked to notify the research team should they require individual NHS R&D clearance.

The discussions were audiotaped with the participants’ permission and were subsequently transcribed. Summaries of the points raised in each discussion were prepared from the transcripts and copies were circulated to the participants.

**Analysis of seminar findings**

The transcripts were analysed using a modified version of the ‘framework’ approach developed by Ritchie and Spencer (1994) for use in applied policy research. The data were analysed by taking different themes in turn, extracting the sections relevant to that theme from the seminar transcripts and then grouping them. The themes were the subject areas of discussion including drivers, inhibitors, discussion on concepts, such as choice and outcomes of NMHV entrepreneurial activity. The analyses for each theme were then crosschecked.
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independently by two of the research team (Rachel Locke and Charlotte Humphrey) before they were finalised by consensus.

1.3.4 Policy mapping and analysis

The aims of this part of the scoping exercise were:

- To identify and describe the broad UK policy background that has a direct or indirect influence on NMHV entrepreneurship and patient choice by affecting the context.
- To provide a more focused discussion of UK health policy and other statements and documents from the UK's health departments that have a direct bearing on this subject, either because they set out explicitly to enable or promote NMHV entrepreneurialism (or have the effect of doing so) or because they have the effect of inhibiting it.

We initially set out the range of health policy initiatives over a 10-year period (since 1996) and identified changing priorities over time (where these are apparent). We then considered in more detail how general priorities for the NHS have affected NMHVs both explicitly and implicitly, some of the possible unintended consequences of particular policies, and possible contradictions of other health policies that may compromise effectiveness.

The policy mapping and analysis is not an exhaustive review and includes only the policy or other communications that the research team believe are of relevance to the topic of the scoping exercise. Policy of only indirect effect, such as overall treasury policy, is considered only briefly, while policy of more direct relevance is discussed at more length, e.g. policy enabling primary care trusts (PCTs) to commission health services from a diverse range of provider types and policy with a specific focus on NMHV roles. To help with this policy analysis, we have drawn on the work of a number of commentators and think tanks. We adopted a critical approach to analysis of policy formation, its expression and the way in which it is taken up and responded to by different actors. Some of our analysis was informed by aspects of discourse analysis, an approach taken in similar studies by the principal investigator (Traynor, 1999), which focuses on subjecting taken for granted definitions and argumentative strategies to detailed scrutiny ( Alvesson and Karreman, 2000; Fairclough, 2001; Fairclough, 2003). One focus for such analysis was the suggestive use of the term 'entrepreneur' in government literature as a signifier associating positive value with a range of preferred behaviours.

1.3.5 Synthesis of evidence and identification of gaps in knowledge

The results of the policy analysis were brought together with the review of entrepreneurial activity and the findings from expert
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seminars and an overall summary and specific range of questions for further research were articulated (See Section 6).
Section 2 Setting the entrepreneurial scene

This section sets out to explore the wide-ranging literature that discusses, describes and, sometimes, defines entrepreneur, entrepreneurship and associated terms. Firstly, it considers what is meant by these terms and the historical development of their definitions from a variety of disciplines and approaches. Next, some of the implications of these definitions in health care are explored. Lastly, it discusses women as a newly emerging group of entrepreneurs.

2.1 What is meant by ‘entrepreneur’?

A great deal has been written about entrepreneurs and entrepreneurial activity, initially in the economics subject area and, more recently, in the business and management literature. Although some of these texts are narrative and celebratory of individuals’ achievements rather than being analytical, there is a separate strand of literature that seeks to understand and theorise about the nature and context of entrepreneurship. More recently, the term has taken on currency within the health care literature (Silver, 1987), and the role of entrepreneurship within nursing, midwifery and health visiting is the focus of the main part of this scoping exercise.

The use of the term ‘entrepreneur’ or ‘entrepreneurial’ is associated with a range of behaviours and activities that are preferred by particular groups in various contexts (Baum and Locke, 2004). Therefore its use is not innocent. Both inside and beyond the literature, the term has been loaded with positive meaning as the driver of change and development (Drucker, 1999). This is in spite of the fact that in the UK, 30% of all small business start-ups will fail within the first 12 months, and that this figure rises to 55% within 3 years. It is notable that within the literature there remains a paucity of data relating to entrepreneurial failure. After a preliminary acquaintance with definitions and use of the term ‘entrepreneur’, it became clear that certain activities that might meet most definitions of entrepreneurial activity may not be labelled in that way by NMHVs. This is not least because of the negative stereotypes associated with the role, which some see as contrary to the nature of professional work and to the trust and ethical values associated with health care (Koivusalo and Mackintosh, 2004; Nicholson and Anderson, 2005). This was borne out in the expert seminars, where all the participants acknowledged that they were involved in entrepreneurial activity in some way, but preferred a range of terms other than ‘entrepreneur’ – such as ‘public servant’ or ‘business woman’ – to describe themselves.
Given this context, decisions about how to determine the scope of our inquiry were not straightforward precisely because these issues concerning definition of the terms were a feature of the discourse itself. As a result, we adopted an inclusive and pragmatic approach to our conceptualisation and our searches, some of which are detailed in Section 1.

2.1.2 Early definitions

The French word ‘entreprendre’ means ‘to do something’ and usually refers to a person who is active and gets things done. The first definition of entrepreneur is attributed to the French economist Cantillon (1680–1734), who saw entrepreneurs as having the skills and motivation to assume monetary risk during periods of imbalance in demand and supply. The essence of entrepreneurship for Cantillon was a personal alertness to such opportunities for gain (Blaug, 2006). Later, Jean-Baptiste Say, writing in 1800, defined an entrepreneur as ‘one who shifts economic resources out of an area of lower and into an area of higher productivity and greater yield’. He argued that entrepreneurs use periods of change and uncertainty to enable them to achieve this shift. Schumpeter (1883–1950), writing during the 1930s, suggested that the entrepreneur was an innovator who produces and markets new goods or services and makes new combinations of already existing materials and forces, creating innovations rather than inventions. For him, rather than being someone who is highly speculative in behaviour, the entrepreneur maximises the benefits of technological advance and can benefit from practical guidance. Schumpeter’s typology has influenced subsequent understandings. According to him, entrepreneurialism can be characterised by:

1. The introduction of a new good.
2. The introduction of a new method of production.
3. The opening of a new market.
4. The conquest of a new source of supply of raw materials.
5. The creation of a new organisation of an industry.

It is the act of combining activities in this context that he considers key.

Schumpeter’s work examined the activities and context of the entrepreneur. More recently, texts have focused on the boundaries of definitions of entrepreneurs and their organisational contexts to answer questions about what activities are entrepreneurial, when they or their organisational contexts move into the mainstream, what is deemed to represent failure and what happens to the entrepreneurs and their organisations after this endpoint. International bodies, such as the Office for Economic Co-operation and Development (OECD) and
Global Entrepreneurship Monitor (GEM)\(^1\), use various types of national data to provide comparative information on these issues (OECD, 2006). These data demonstrate the levels of such activities and the elements that contribute to them, so enabling a better understanding of the national organisational context (Hayton, et al., 2002). This in turn can lead to policy changes to promote entrepreneurialism that is culture specific (see Section 3 for more details).

Within the scope of these debates, a great many writers have been keen to define the phenomenon of entrepreneurialism exactly. The breadth of these definitions and characterisations does not give a sense of either consistency of focus or emerging consensus. Many definitions that we have reviewed are normative statements or promotions of the concept. The most notable feature of many of the definitions is that they are positively loaded and, as such, they are available to those who wish to evoke or encourage positive behaviour or characteristics without necessarily being precise about what they are. However, although the literature has not produced a consensual definition, Herron and Herron (1991) propose that ‘entrepreneurship theory may be used effectively by nursing to build professional practice models which foster the joint realisation of both nursing and organisational goals’ and they go on to identify two general features within business. First, entrepreneurship is about ‘innovation through reallocation or reconfiguration of resources for the purpose of creating benefit’ and second, that the entrepreneur possesses an ‘awareness or alertness to the opportunity’ to take such action; this is in line with the early definitions of entrepreneurship (Herron and Herron, 1991).

### 2.2 ‘Intrapreneur’: the entrepreneur within the organisation

Because, as we will show later, many NMHV entrepreneurs operate inside large organisations (usually the NHS), we examine the concept of ‘intrapreneurship’. Entrepreneurship is not confined to individual start-up organisations, although as a mould-breaking activity it can be seen to threaten the status quo within many existing organisations.

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\(^1\) The Global Entrepreneurship Monitor (GEM) research programme is an annual assessment of the national level of entrepreneurial activity, which was established in 1997. GEM is the world’s largest and longest-standing study of entrepreneurial activity and is scaled on population not labour force in the formal sector rather than the informal sector. The results of GEM data analyses are used as key benchmarking indicators by regional, national and supranational authorities worldwide. GEM surveys analyse total entrepreneurial activity (TEA), defined as the share of adults in the population aged 18–64 who are actively involved in starting a new business or managing a business less than 42 months old. Data are captured for two categories: the nascent entrepreneur, who is an individual who has taken action and created a new business in the past year and expects to share ownership but has not yet paid salaries and wages for more than 3 months, and the owner/manager of a new firm that has paid salaries and wages for more than 3 months but is less than 42 months old (Reynolds et al., 2002).
Within this issue lies another of the historical dilemmas of defining entrepreneurship: do entrepreneurs stabilise disequilibriums by identifying new products or do they destabilise the status quo in order to bring about change and progress? One reinterpretation of this question proposed in the 1980s was the development of intrapreneurship – the encouragement of entrepreneurial activity within the organisation to reinvigorate established businesses. A classic example of intrapreneurship was the development at 3M of the Post-it® note by Art Fry, which was launched in 1981. The publication in 1985 of Pinchot’s *Intrapreneuring: Why You Don’t Have to Leave the Corporation to Become an Entrepreneur* further clarified the specifics of this role, where the creative innovation required is encouraged by the corporation (or NHS), which also benefits from the process. Moss Kanter suggests in her seminal 1988 article *When a thousand flowers bloom* (Moss Kanter, 1988) that it is important to actively facilitate such innovation, which she describes as:

- uncertain – because of both the creative and organisational processes
- fragile – because it is knowledge intensive with steep learning curves
- political – because of its competition with the status quo
- imperialist – because it crosses boundaries and territories.

Intrapreneurship therefore needs the right conditions in which to flourish. Moss Kanter suggests that these are found where organisations are flexible and provide for quick action, intensive care, coalition formation and connectedness.

Although there continues to be much interest in the ‘conventional’ business entrepreneur, later literature that examines broader conceptualisations of entrepreneurship has proved more relevant to the focus of this scoping. It is to these we now turn.

### 2.3 How do we recognise an entrepreneur? Studies of characteristics and motivation

From approximately 1980 onwards, a further range of literature within psychology and, more rarely, psychoanalysis, sets out investigations into the personal characteristics of entrepreneurs in much the same way that leadership and leaders have been studied. Some of these studies attempt to discover whether those identified as successful entrepreneurs differ in any way from their peers (Jennings et al., 1994). Many of these studies do not differentiate between entrepreneurs and senior managers in leadership roles within corporations on the grounds that similar traits – growth, innovation and flexibility – are found in both groups. Furthermore, personality traits show there are more similarities across the two groups than within the group of ‘conventional’ entrepreneurs. Conventional entrepreneurs are small business owners, many of whom, it has been
argued, do not possess ‘genuine’ entrepreneurial traits because they ‘inherit or simply replicate an existing or proven form of business’ (Watson, 1995). Almost all, however, are men. This focus on personality traits and behaviour remains a subject of interest, especially when combined with information on context (Hayton, et al., 2002), be it organisational or cultural.

In addition, the concept of the ‘serial’ entrepreneur also emerged during the 1980s to support the notion of an individual with a predisposition to entrepreneurial behaviour (MacMillan, 1986). The serial entrepreneur is the individual who over a lifetime is involved in a number of business start-ups, often moving away from their original business area to do so. Research here is less well developed but there are indications that context in relation to this group is also important. Exploration of the activities of existing entrepreneurs undertaken through our research seminars suggests that this is a recognisable phenomenon in health care, which sometimes involves transitions between intrapreneuring within the NHS and entrepreneuring outside of the organisation.

2.4 Social entrepreneurialism in an international context

Much of the ‘entrepreneurial’ work of NMHVs has been assumed to be ‘social’ entrepreneurship (see Section 3). The term ‘social entrepreneur’ is inextricably linked in an international context with the work of Bill Drayton, who founded the Ashoka organisation in the USA in 1979 to develop social entrepreneurs. He suggests social entrepreneurs recognise when a part of society is stuck and provide new ways to get it unstuck. Social entrepreneurs are characterised by him as having:

- a powerful new system-changing idea
- creativity, both in goal-setting and problem-solving
- the potential for widespread impact
- the entrepreneurial quality that is required to engineer large-scale systemic social change
- strong ethical fibre, as significant social change requires those affected to take many leaps of faith, which individuals will not take if they do not innately trust the proponent of such change.

Social entrepreneurs are said to find what is not working and solve problems by changing the system, spreading the solution and persuading entire societies to change. In this sense they differ from those running social enterprises (who are people seeking to make improvements within existing systems) because social entrepreneurs seek system change (Hartigan and Billimoria, 2005). In Drayton’s words ‘Social entrepreneurs are not content just to give a fish or teach how to fish. They will not rest until they have revolutionised the
fishing industry’. Drayton’s work promoting social entrepreneurs has been described and developed by Bornstein (2004). Drayton’s methods require a radical approach to assessing ideas, programmes and the people behind them. Ashoka’s work began in the USA, where the notion of public and community services is less well embedded than elsewhere. Ashoka uses terminology that combines the affinity felt for entrepreneurial activity in the USA with the social responsibility that is more acceptable to other parts of the world. In Europe, the development of the Schwab Foundation for Social Entrepreneurs in 1998 is seen as complementing the macro work of the World Economic Forum at a local micro level (Hartigan and Billimoria, 2005).

Meanwhile the World Health Organization (WHO) had already explored the role of social entrepreneurship in health through the development of its Healthy Cities Project (de Leeuw, 1999)². This movement aims to improve the health of cities around the world through multilevel interventions and intersector collaborations, including social enterprise. Social entrepreneurship and social enterprise are now the subject of many books (e.g. Bornstein, 2004; Law and Baderman, 2006), organisations (e.g. Ashoka and UnLtd) academic papers (e.g. Shaw et al., 2002) and whole academic departments (e.g. the Center for the Advancement of Social Entrepreneurship [CASE], Duke University’s Fuqua School of Business; the Skoll Centre for Social Entrepreneurship, Said Business School, Oxford University, UK). All these initiatives help to trace the development of social entrepreneurship and its interpretation. Such work has also provided a bridge into a greater understanding of and engagement with the needs of those that Prahalad (2004) describes as being at the bottom of the pyramid, so helping to improve the quality of life in some of the most ‘difficult’ and ‘excluded’ communities. Social entrepreneurs identify unmet social need and generate solutions based upon a close understanding of the views of those most directly affected. At the same time, multinational corporations are seeing an expanding market that they have so far overlooked. Collectively, the world’s 5 billion poor have vast untapped buying power, which represents enormous potential for companies who learn how to serve this market by providing the poor with what they need. However, the task of initially developing this market often falls on those who start through the motivation provided by social entrepreneurs.

An example of the way in which social entrepreneurs help to develop markets is the Grameen Foundation, which was founded in the USA in 1997 by Alex Counts. The Grameen Foundation aims to assist poor/low income women to develop microenterprises in order to break through the poverty barrier, so extending a microfinancing initiative first started by Dr Mohammad Yunus, an Indian economics professor, in

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²The Healthy Cities Project (now in its fourth phase [2003–2008]) specifically targets health inequalities and urban poverty. It is established in all 6 WHO regions of the world and involves over 1200 cities and towns from over 30 countries.
Bangladesh. Microenterprises are described as very small businesses consisting of fewer than 10 employees, which form the economic backbone of many countries around the world, although many are officially ‘invisible’. In the main, microenterprises are operated by entrepreneurial individuals who are often from lower income brackets and are women. The Grameen foundation is a not for profit organisation that uses microfinancing and innovative technology as the means to address issues of global poverty and support employment opportunities for some of the world’s poorest people. The United Nations declared 2005 as the International Year of Microcredit, advocating greater involvement from the financial sector to support the often untapped, entrepreneurial spirit of individuals in communities around the world.

2.5 Entrepreneurs and social entrepreneurs: the UK experience

The OECD has consistently identified the UK economic environment as being favourable for the development of entrepreneurial activity because it is the second least regulated economy in the world. However, as the 2004 GEM report on the UK shows (Harding, 2005), a number of local factors continue to militate against the UK activity increasing above 6.3% of total entrepreneurial activity (TEA) in the adult workforce. These negative factors can be summarised as:

- a need to build networks of entrepreneurs
- the slow speed of development, especially in the transfer of technological advances from universities into the entrepreneurial community
- aspirational modesty, especially in the women entrepreneurs and those from ethnic minorities
- problems in accessing finance, especially for women and ethnic minorities
- an unhealthy level of fear of failure that is part of the UK culture.

The situation is, however, improving. In a speech to the Ethnic Minority Business Forum in March 2006, the Secretary of State for Trade and Industry reported that there were half a million more businesses today than in 1997 and 1500 new businesses were starting up every day. In our literature review we have noted the changing fortunes of the term ‘entrepreneur’ in UK social policy and government speeches (see also Section 3). The government initially promoted the term ‘entrepreneur’ with an expectation that it could come to have the positive meaning that it is generally accorded in the US context. Social enterprise and social entrepreneurs became the engine of change for the public services sector. The term first came to wider public prominence in the UK in the first policy speech given by the new Prime Minister, Tony Blair, on 2 June 1997 at the Aylesbury Estate in the London Borough of Southwark, where he stated:
'For the same reason we will be backing thousands of “social entrepreneurs”, those people who bring to social problems the same enterprise and imagination that business entrepreneurs bring to wealth creation. There are people on every housing estate who have it in themselves to be community leaders – the policeman who turns young people away from crime, the person who sets up a leisure centre, the local church leaders who galvanise the community to improve schools and build health centres.’

This was endorsed in the same year by Leadbetter’s (1997) publication for the Demos think tank, in which he describes social entrepreneurs as applying the same enterprise and imagination to social problems as commercial entrepreneurs apply to wealth creation. Because of this focus on welfare and social benefit, social entrepreneurialism has been seen as an appropriate model for developing nursing entrepreneurial activity, particularly when applied to the community setting, although it has been recognised that activities in health care, whether social or commercial, will require effective regulation to safeguard patients (Saltman et al., 2002). In the expert seminars, some participants expressed scepticism about the current emphasis on the concept of social entrepreneurship in the NHS. It was suggested that the term was a smokescreen used to disguise and make more acceptable the government’s wish for greater plurality of service providers.

Development of the critical networks required for social entrepreneurship to function effectively has also been supported in the UK by developments such as UnLtd. UnLtd, which is also known as the Foundation for Social Entrepreneurs, was founded in 2000 by seven partner organisations to promote and develop the major contribution social entrepreneurs can make to society. UnLtd’s Millennium Awards are funded by the income generated from an investment of £100 million given to UnLtd by the UK Millennium Commission, one of the National Lottery distributors.

In addition to the term ‘entrepreneur’, we have seen the beginning of the use of the more acceptable term ‘enterprise’. This is exemplified by the creation of the Department of Health Social Enterprise Unit, which was set up in 2006 following the original unit that was created in the Department of Trade in 2002. Our review has suggested that there is a sense in which the concept of enterprise does not carry the connotations of radical change of existing systems that is involved with the work of social entrepreneurs. This perhaps reflects a more mainland European position, with a resistance to the concept of free markets.

The GEM programme has now developed specific reports on social entrepreneurs as a subsector of the enterprise economy and the relationship between these two sectors becomes increasingly important. In the expert seminars, participants made the point that commercially driven activities and socially driven activities are not necessarily at odds. It was suggested that an individual could be both a commercial and social entrepreneur, as there is ‘such a lot of
interaction’ between the two activities. Developing an understanding of the similarities and differences between social and commercial entrepreneurship enables a better understanding and appropriate expectations from policy-makers of the contributions that each can make. These are already the subject of discussion (Shaw et al., 2002) in the UK and are now being considered in relation to a future research agenda (Austin et al., 2006). Austin et al. suggest:

- Market failure will create differing entrepreneurial opportunities for social and commercial entrepreneurship.
- Differences in mission will be a fundamental distinguishing feature between social and commercial entrepreneurship that will manifest itself in multiple areas of enterprise management and personnel motivation. Commercial and social dimensions within the enterprise may be a source of tension.
- Human and financial resource mobilisation will be prevailing differences and will lead to fundamentally different approaches in managing these resources.
- Performance measurement of social impact will remain a fundamental differentiator, complicating accountability and stakeholder relations.

Austin et al.’s analytical framework for social entrepreneurship (see Figure 1) is presented as a Venn diagram with the opportunity circle at the top because this is often the initiating point for entrepreneurship. The two enabling variables – people and capital resources – are the bottom circles. The three circles intersect, reflecting the overlapping and interdependent nature of the variables. At the centre is the social value proposition (SVP) as the integrating variable. Surrounding all three circles are the contextual forces shaping the other variables that require scrutiny by the entrepreneur.
In considering the differences between commercial and social entrepreneurs and the role they will play, it is important to know who the new entrepreneurs might be. From the preceding data on nurses (Appendix 1), it is apparent that the vast majority of nurse entrepreneurs will necessarily be female. An understanding of how women now appear in this role is thus essential.

### 2.6 Women as entrepreneurs

One of the main criticisms of much of the classical entrepreneur literature, as we have noted previously, is that it has focused on successful individuals who are predominantly male and involved in entrepreneurial activities associated with personal and financial gain, rather than social objectives. This does not reflect either the purpose or gender profile of nursing in the UK (as set out in Appendix 1). Much of the methodology was developed during investigations of the behaviours and activities of male entrepreneurs and it is argued that these may not be the most appropriate measures to investigate female entrepreneurship. Until relatively recently, women’s entrepreneurship was considered to be ‘invisible’ and was studied only as a sub-field (Hirsch and Brush, 1987). Contemporary researchers are now beginning to question the relevance of some these earlier findings, particularly within the context of gender differences. Following the first publication on female entrepreneurship – a qualitative study investigating the motivational drivers and inhibitors of 20 female entrepreneurs in the USA, which was conducted by Eleanor Schwartz in 1976 (Schwartz, 1976; cited in Hirsch and Brush, 1987) – increasing numbers of studies have been conducted in this area worldwide. While much of the earlier focus was on describing
distinctive individual characteristics, goals, motivations and attitudes towards start-up, as the 1990s witnessed more women entering the self-employment/new business arena around the world, novel studies of female entrepreneurs began to emerge in the literature. These studies begin to capture some of the unique differences between the genders in relation to:

- Individual characteristics and competencies, for example, why women were motivated to engage in entrepreneurial activities; what influenced the types of business they were involved in; their attitudes and educational and business experiences.

- Business characteristics, for example, financial resources (access to and availability of start-up and growth capital and their relationship to business survival); management skills, including risk-taking propensity; performance and growth strategies; barriers and challenges.

- Environmental/cultural factors, such as family-related factors.

Self-employment is not synonymous with entrepreneurship but these terms inherently overlap and, as such, provide an avenue through which to explore entrepreneurial characteristics, including differences between the genders. For example, men and women view success differently. Men tend to evaluate success principally on goal achievement as measured in terms of financial profitability (business and personal income). Women – particularly those in more ‘traditional female’ industries, such as retail, hospitality and services, rather than the less traditional, more male-dominated industries – emphasise life factors as part of their measures of success, including control over their destiny, ongoing relationships with clients and sense of fulfilment.

Worldwide, female entrepreneurship has been researched most in North America; less information is provided in the literature for Europe and the UK. We will now explore female entrepreneurship in these geographical areas.

2.6.1 Female entrepreneurship: global context

Globally, women make up more than half of the workforce (UNIFEM, undated). The GEM project provides a map of worldwide entrepreneurial activity annually. The most recent data (the 7th GEM)
gathered from 35 countries and involving a total labour force of approximately 784 million people, show that 1 adult in 11 is an entrepreneur, with wide variations in the types and levels of activity. Women still form a minority of those taking part in entrepreneurial initiatives; however, more women would be involved if they did not have a fear of failure. A recent report on the findings of the second OECD conference on women’s entrepreneurship in small and medium-sized enterprises (SMEs) found that in many countries, including Brazil, Ireland, Spain and the USA, women are now starting new companies at a faster rate than men (Eurochambres, 2004).

According to the GEM project, the proportion of men or women starting up their own businesses and becoming potential employers is greater in middle-income countries (Argentina, China and South Africa) than in high-income countries (Japan and the USA), as defined by their per capita gross domestic product (GDP) and GDP growth rates. Further analysis of the type of start-up activities demonstrated that consumer-oriented businesses outnumber businesses started in the service sector in the middle-income economies, while high-income economies are twice as likely to have more new business services (Minniti et al., 2005). Globally, male entrepreneurial activity remains greater than female entrepreneurial activity within low-, middle- and high-income countries. The two primary reasons men or women become involved in entrepreneurial ventures are:

• business opportunity (the desire to take advantage of an entrepreneurial idea) – this reason was similarly frequent for men and women: 77.9% of men choose entrepreneurship in order to exploit an opportunity versus 71.4% of women (Minniti et al., 2005).

• necessity (employment options either absent or unsatisfactory) – necessity was a factor for just 19.1% of men versus 24.8% of women (Minniti et al., 2005).

In terms of the principal drivers and inhibitors, current literature focuses on the notion of initiating or triggering events in relation to start-up entrepreneurial activities, and triggers influenced by internal and external organisational factors. These have been classified as (Morris et al., 2006):

• push (unemployment or job dissatisfaction) or pull (market opportunities) factors

• negative (divorce or job dissatisfaction) or positive (windfall inheritance or invitation from a supplier) circumstances

• controllable (planned deliberate strategy) or uncontrollable (sudden death of family member) forces.

While governments, industry and policy-makers may recognise that women are a potentially important and latent source of economic growth, global recognition of women’s enterprise initiatives and their influence on policy remains limited despite worldwide policy efforts
aimed at providing greater support to would-be female entrepreneurs (Harding et al., 2004).

**2.6.1.1 Global context: numbers**

Overall the number of women starting up new businesses is on the increase (Acs et al., 2005) and a positive correlation has been shown between rates of female entrepreneurship and economic growth (Reynolds et al., 2002). However, GEM project surveys conducted between 2001 and 2004 continue to report a persistent gap between the levels of male and female entrepreneurship. The size of this gap varies between countries, with the most prominent gap observed in high-income economies where the opportunity-driven versus necessity-driven factors may be influenced by the availability of health care and childcare support (Minniti et al., 2006).

It is estimated that women-owned businesses account for between one-quarter and one-third of businesses in the formal sector and this proportion is likely to be much higher in the informal sector (where many small businesses may fall under the tax radar, so becoming officially ‘invisible’).

The magnitude of this activity in the informal sector may, in part, be necessity-driven, particularly where the national per capita income is low and there is a lack of alternative employment opportunities. By contrast, in very high income countries, entrepreneurial individuals are more opportunity-driven, as they have access to more resources and are thereby more motivated to develop ideas, take risks and exploit opportunities (Minniti et al., 2005). One study found that levels of female entrepreneurial activity are more markedly related to national per capita income than that of males, citing greater employment sensitivity in terms of the local environment and non-monetary incentives, such as necessity, flexibility, family and social needs (Burke et al., 2002). However, the number of women-owned businesses in the UK remains low in comparison to many other countries in North America, Australasia, Europe and countries in the Far East and South America (Reynolds et al., 2002).

**2.6.1.2 Global context: characteristics**

Women are more likely to start up new enterprises in the service sector. The peak age to become involved in women-owned enterprises is 25–34 years, particularly in low-/middle-income countries. Often women in low-/middle-income countries have minimal or no secondary education whereas women in high-income countries tend to be better educated and slightly older (35–44 years) at start-up (Minniti et al., 2004). As necessity is often the main driver of women-owned businesses, risk is minimised by starting up smaller businesses, which are often consumer-oriented and so need less start-up capital than service-oriented businesses. As a consequence, many of these
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Businesses tend to grow more slowly and potentially create fewer employment options for others.

### 2.6.1.3 Global context: drivers

Female enterprise is generally classified as necessity-driven rather than opportunity-driven and is characterised by a number of personal and socio-economic factors, such as age, education, previous work experience, the influence of other female entrepreneurs and social and family circumstances (Minniti et al., 2006). For many women – especially those in lower-income countries – being able to generate income and gain independence while still meeting family and social responsibilities is both liberating and empowering (Kantor, 2001; Minniti et al., 2005; Sheikh et al., 2002). While there are many key similarities in the personal factors that influence individuals to move towards entrepreneurship, the primary similarity can be found in their motivation for starting up a new business venture: financial security, need for autonomy and a response to a business opportunity. There is little agreement in the literature as to the involvement of personality and personal attributes. Although previous work experience and perception of success do seem to be key observed differentials between men and women entrepreneurs, other notable differences principally relate to:

- **Emphasis** – men tend to emphasise the greater desire to be their own boss with the aim of increasing personal income, whereas women, in addition to being their own boss, stress the need for personal challenge, greater job/life satisfaction, independence and the flexibility to meet combined work and family responsibilities.

- **Necessity** – the need to work and earn an income is more widespread among women than men, largely due to unemployment or a lack of alternative work opportunities. Necessity is a particular factor among women in low-income countries, where the opportunity to necessity ratio for start-ups is 1:7 compared with 1:6 in high-income countries (Minniti et al., 2005).

### 2.6.1.4 Global context: barriers and constraints

It is common for both men and women to experience a range of constraints, mainly at the start-up stage of a new business. These constraints are similar for the genders, but they may be more pronounced among women as a result of societal perceptions of women, their roles and responsibilities (Kantor, 2001). However, a number of specific cultural and practical barriers face women entrepreneurs in many countries and this has major implications for policy-makers. Some of the key differential barriers include perceived difficulty in accessing external business finance, both at start-up and when needing to grow a new business venture; being less likely than men to be members of business or employers’ associations; and women’s apparent disinclination to take on risk compared with men.
Other factors include a reluctance to transform business ideas into practice due to a lack of confidence, fear of failure, lack of role models, and limited mentoring opportunities and networking possibilities (Minniti et al., 2006). Additional factors that have been reported by the Women’s Entrepreneurship Development and Gender Equality organisation⁴ include limitations imposed by location and mobility, social and family responsibilities – factors that may become magnified among women who have a disability (Kantor, 2001).

The greatest amount of literature on female entrepreneurship has been published for the USA, but it should be noted that this may not reflect contextual and cultural dynamics in other countries, such as the UK.

2.6.2 Female entrepreneurship: North American context

Women-owned businesses are the fastest growing sector in the business markets in the USA and have grown at nearly twice the rate of all US firms since 1997 (17% versus 9%, respectively) (Center for Women’s Research, 2004). It is reported by the Center for Women’s Research that women-owned businesses (defined as privately held firms majority owned [≥50%] by women) are driving economic growth and are a equal financial competitor to all other business growth.

2.6.2.1 North American context: numbers

Research data gathered from the US Census Bureau and tabulated by the Center for Women’s Research show that as of 2004, approximately 10.6 million privately held businesses, which is nearly half (48%) of them in total, are partly or solely owned by women. Employment through these woman-owned businesses has expanded at twice the rate of all firms (24% versus 12%), with increasing economic dominance (39% versus 34%). Another 4 million businesses are jointly owned (50:50) by women and men. Overall, this means that in the USA 1 in 18 women are business owners and 1 in 5 women from ethnic minorities have their own business enterprise (Harding et al., 2004).

2.6.2.2 North American context: drivers

The principal drivers of American female entrepreneurs reflect the drivers of women worldwide and include the inspiration of launching

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⁴The Women’s Entrepreneurship Development and Gender Equality (WEDGE) spearheads the International Labour Organization’s InFocus Programme on Boosting Employment Through Small Enterprise Development (SEED) work in the field of female enterprise. The SEED network is an online resource for women setting up their own businesses. For more information go to: http://www.ilo.org/dyn/empent/empent.portal?p_lang=EN&p_prog=S&p_subprog=WE
an entrepreneurial idea and frustrations in previous work environment (data from a study of 800 male and female entrepreneurs undertaken by the National Foundation of Women Business Owners cited in Centre for Women’s Business Research, 1998). In addition, women starting up on their own tend to be older than their male counterparts, are the oldest or only child and have an entrepreneur in their family background (Affholder and Box, 2004).

2.6.2.3 North American context: barriers and constraints

Among the principal constraints to women are lacks of managerial experience and business background, which lead to training needs, particularly at start-up. In addition, there is still a struggle to access finance, especially in terms of acquiring venture capital funding (Affholder and Box, 2004). A further barrier may be an element of discrimination.

2.6.3 Female entrepreneurship: European context

The level of female entrepreneurship in Europe remains low, both in relation to that of males and as a proportion of the female population (Smallbone et al., 2000). In order to facilitate the creation of businesses by women, the European Economic Association member states (European Union and most European Free Trade Area countries) have created various initiatives addressing issues such as start-ups, funding, training, mentoring, information/advice and networks. The European Commission has addressed the issue of female entrepreneurship within the framework of various government policies and the private sector and via multiple agency and women’s business association initiatives (e.g. Structural Funds, the European Employment Strategy, the fourth Community Action Programme on Equal Opportunities for Women and Men [http://ec.europa.eu/employment_social/gender_equality/index_en.html], the Framework Strategy on Gender Equality [2001–2005] and the 3rd Multi-Annual Programme for SMEs in the European Union) and the European Network to Promote Women’s Entrepreneurship (WES)5.

2.6.3.1 European context: numbers

Women make up half the population of Europe, yet they own less than half of the businesses aided by business-support organisations (Smallbone et al., 2000).

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5 The European Network to Promote Women’s Entrepreneurship (WES) was created in October 1998 by a Swedish initiative; it was officially launched in June 2000. This network is composed of 16 members representing all the countries of the European Union, except Luxembourg, plus Iceland and Norway. The delegates in the network represent central national governments and institutions with the responsibility to promote female entrepreneurship. One collaborative research project undertaken with the Austrian Institute of Small Business Research has led to reports and publications on good practices in the promotion of female entrepreneurship and a database on female entrepreneurship.
2.6.3.2 European context: characteristics

A recent survey of 1356 female entrepreneurs across 25 European countries (Eurochambres, 2004) found that women were:

- typically educated to a tertiary level
- ran a microenterprise
- started the business before the age of 35 years
- worked over 48 hours a week (typically 60 hours)
- were married with children but had no help at home.

2.6.3.3 European context: drivers, barriers and constraints

The drivers for women in Europe are similar to those of other women around the world.

Across the world, many of the barriers to women entrepreneurs are also similar. In Europe, a recent study found that these barriers include difficulties accessing finance, particularly at the nascent start-up phase; confidence issues related to a lack of business skills and management training; limited marketing skills and training opportunities; and a lack of IT skills. In addition, women lacked knowledge and awareness of business-support providers and female-specific training. Other factors included variable levels of childcare availability, a prejudiced societal perception of the role and responsibilities of women and unequal opportunities for men and women (Smallbone et al., 2000).

2.6.4 Female entrepreneurship in the UK: context

In 2004, total employment (based on the 1993 International Classification by Status in Employment) showed a total labour force of 28.01 million in the UK, of whom 12.97 million (46%) were women. In the female workforce, 0.96 million (7.4%) were categorised as ‘employers and own account workers (self-employed)’, as compared with 2.6 million in the male workforce (17.3%). Thus, with respect to the total labour force, self-employed women represent 3.4% while self-employed men account for 9.2%. However, these figures only provide an indication of the working activity, as they do not directly correlate with business start-up and ownership figures. They are therefore likely to underestimate entrepreneurial activity, particularly among women and among women involved in family owned businesses, where co-ownership can be masked.

The UK compares poorly with other countries with respect to the gap between male and female entrepreneurship. In 2001, the UK was ranked 26th out of 29 countries in terms of the balance between male and female entrepreneurs (Harding et al., 2004).
From a study conducted in 2001 by Strathclyde University in collaboration with the National Foundation for Women Business Owners and IBM (Carter and Anderson, 2001), it was reported that:

‘Women entrepreneurs represent one of the fastest growing segments in the UK economy, ... Women entrepreneurs are creating a more gender-balanced business marketplace through a rapid increase in the number of women-owned business start-ups ... despite a gap in access to capital’.

Although they have yet to achieve parity with female entrepreneurship in the USA, levels of female self-employment have been gradually increasing in the UK in recent years (Carter and Anderson, 2001). Self-employed women now account for 6.8% of the UK’s working population (Harding et al., 2005; Acs et al., 2005). According to the women’s enterprise national body, Prowess, 12–14% of businesses are majority owned by women. The development of the Strategic Framework for Women’s Enterprise in 2003 aimed to raise awareness by setting a target that will see the proportion of businesses that are majority owned by women rise from 15% to 20% by 2006 (Department of Trade and Industry Small Business Service, 2003). In 2006, the Chancellor of the Exchequer, Gordon Brown, revealed that if Britain could achieve the same levels of female entrepreneurship as the USA, 750,000 more businesses would result. To encourage this growth further, increased childcare and training opportunities for women were announced as part of the 2006 budget.

**2.6.4.1 UK context: characteristics**

More women in the UK today are starting up businesses, which are gradually encompassing a variety of industries (Carter and Anderson, 2001). Nevertheless, a gender divide is still evident, with women more often than men (5.8% versus 4.9%) operating businesses within sectors that have been seen as ‘traditionally’ female, such as socially orientated retail and service sectors (Minniti et al., 2005). This is particularly evident when looking at the figures for four UK regions (East Midlands, London, the North East and the South East) where 48% of female entrepreneurs own businesses in the service sector versus 36% of men; female entrepreneurs tend to have smaller businesses; and the start-up period and processes tend to be longer for female entrepreneurs (Department of Trade and Industry Small

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Prowess is the UK association of organisations and individuals (over 180 members) who support women to start and grow businesses through the development of an effective women-friendly business-support infrastructure and enterprise culture. This is achieved by raising awareness, providing capacity building support to organisations that provide enterprise support services and by lobbying and advocacy at local, regional, national and European levels. Prowess supports 100,000 women each year to start 10,000 new businesses that contribute an additional £1.5 billion to the economy.
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Business Service, 2003). In 2003, Everywoman Ltd\(^7\) reported that, of the estimated 1 million UK businesses owned by women, 11% were based in London, 35% in the South, 29% in the North and 21% in the Midlands. Most businesses were less than 3 years old and 50% had been established in the previous 5 years. The majority of the women-owned businesses were focused in the retail and wholesale (26%) and service (33%) sectors; 51% of women ran their businesses from home and 70% of women had never run a business before. In addition, where women work in clusters, such as in the business sector, female entrepreneurship gains greater strength and influence. In social enterprise and rural communities, women’s entrepreneurial activity is higher than that of men (Harding et al., 2004).

Other key characteristics of entrepreneurs are that:

- Women entrepreneurs in the UK tend to be younger than their male counterparts (50% of women are aged 16–44 versus 33% of men) (Barclays Bank SME Research Team, 2004).
- Women are less likely to be married than their male counterparts (60% versus 69%), although they are twice as likely to be widowed, divorced or separated (Barclays Bank SME Research Team, 2004).
- Women entrepreneurs are slightly better educated than men (20% of the male respondents had no qualifications versus 12% of the women) (Barclays Bank SME Research Team, 2004). Similarly, Carter and Anderson (2001) found that women are more likely to be educated to tertiary level and/or have vocational qualifications. In addition, they found that, compared to their male counterparts, women tended to: be more innovative; provide a product or service unfamiliar to the market that has been developed in the last year; have fewer competitors; be more likely to use modern technology in their products or services. Women are also more likely to collaborate with research institutes, such as universities (11.5% versus 3.8% of men), and to look for externally funded research and development collaborations. Unlike men, women are less likely to collaborate with their competitors (Carter and Anderson, 2001).
- Women entrepreneurs are slightly less likely than men to have previous experience of setting up or running a business (32% versus 38%) but are likely to be more adventurous at starting up a business in an area in which they had not previously been employed (Barclays Bank SME Research Team, 2004).

\(^7\)Founded in September 1999, Everywoman Ltd launched as its first service the website www.everywoman.co.uk. It was the first interactive website for women in the UK and is now the leading online network for women starting or growing a business. With over 100,000 signed-up members, everywoman.co.uk provides users with relevant information, appropriate services and additional resources.
Another study found that women in the UK are significantly less likely than men to think that they have the skills to start a business or to have or know of entrepreneurial contacts. Women are much more likely than men to: fear failure; obtain finance from friends, family and government sources; invest fewer personal resources into their business. Women are less likely than men to apply for external finance but when they do they are more likely secure funding from a range of other sources (Harding et al., 2004).

The majority of businesses started by women employ less start-up capital, use known technology and target existing markets (Acs et al., 2005).

2.6.4.2 UK context: drivers, barriers and constraints

Most UK female entrepreneurs are opportunity driven.

There are a number of common factors that present barriers for women making the transition into self-employment or social enterprise in the UK. These can be grouped into the following categories:

- Lack of business support
  - Many women feel there is a lack of role models or women in business who are willing to mentor, support and advocate entrepreneurial activities.

- Finance and capital funding
  - Traditional credit-scoring systems can discriminate against women, who tend to have a less detailed and more fragmented financial track record than men. There is also a failure by some lenders to understand and appreciate the differing motivations of entrepreneurs.
  - Women own fewer assets than men and so have less collateral for a loan.

- Impact of combining family/childcare responsibilities and work.

- Limited access to informal and formal business network mentors or peer support can be a major barrier for women starting new business ventures, particularly for those without previous experience. The ability to develop and create robust networks has been shown to have a positive effect on new business ventures and to significantly improve profitability. In general, men tend to operate in much stronger networks than women. Women also do not tend to collaborate with competitors to the same extent as men.

- Skills, self-belief, self-esteem and confidence
  - Women are less likely to perceive or identify themselves as entrepreneurs, describing their work as entrepreneurial rather themselves as the entrepreneur. As a consequence, they can underrate their performance/skills when compared to their male business-orientated counterparts. Many women state that they
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need additional skills and training, suggesting a lack of confidence in their own abilities.

The problems faced by women are compounded if they are from ethnic minorities. Women from ethnic minorities face similar – but not identical – problems to those that women entrepreneurs encounter as a whole; however, they also have access to different resources (Walding et al., 2000).

2.7 Conclusion

The development and interpretation of the term ‘entrepreneurship’ has changed over time and has expanded to recognise different types of entrepreneur such as the intrapreneur and serial entrepreneur. More recently, we have seen the rise of the concept of social entrepreneurialism, and this is now being promoted to serve those areas of society that are not being well served by the incentives inherent within the commercial sector.

Developments in health care, such as the changes in primary care commissioning, mean that the entrepreneurial contribution within this sector may largely be made by NMHVs, who are predominantly female and therefore face particular obstacles to becoming entrepreneurs. Among these barriers are a lack of confidence, limited acceptability of women starting up new enterprises, lack of networking and skills training opportunities and lack of access to finance. Many of the participants in our expert seminars spoke from personal experience about such constraints. However, they did not identify these as being strongly related to their gender, instead such constraints were regarded as generic problems for people who were accustomed to working as nurses in the NHS (see Section 5). Many developed countries, including the UK, have established a range of organisations and policies to promote and support micro-enterprise initiatives by women entrepreneurs. Nevertheless, the level of UK female entrepreneurship continues to fall behind that seen in much of Europe and the USA.
Section 3  The policy context

3.1  Introduction

This section focuses on how UK health policy has not only enabled (or not enabled) nurse entrepreneurialism, but also on how nurse entrepreneurialism and innovation more generally have been promoted and represented within policy and by policy-makers. First we sketch out some of the differences in health policy emphasis across the four countries of the UK as well as the influence of cross-cutting government policy on this topic. Next, we provide a chronology of relevant policy within a 10-year period from 1996. Finally, we provide a more focused discussion of UK health policy and other statements and documents from the UK’s Health Departments that have a direct bearing on this subject, because they either set out explicitly to enable or promote nursing entrepreneurship (or have the effect of doing so) or have the effect of inhibiting it.

The policy mapping and analysis does not provide an exhaustive review and includes only the policy or other statements, guidance or speeches that the research team believe are of relevance to this scoping exercise. Policies with more indirect effects, such as overall treasury policy, are considered only briefly. Policies with more direct relevance, such as that enabling PCTs to commission health services from a diverse range of provider types, and policies with a specific focus on nursing roles are discussed at more length. (See also Appendix 6 for further details of the various arrangements affecting primary care.)

3.2  Policy diversity in the the UK

Since 1997, devolution has led to differences in the NHS structure and funding streams in the four countries of the UK. This has also led to differences in patient satisfaction, waiting times and activity (Alvarez-Rosete, et al., 2005). Each country’s equivalent to The NHS Plan: A plan for investment, a plan for reform (Department of Health, 2000) – Our National Health: A plan for action, a plan for change (Scottish Executive Health Department, 2000), Improving Health in Wales: A Plan for the NHS with its partners (National Assembly for Wales, 2001) and Investing for Health (Northern Ireland Executive, 2000) – and subsequent legislation laid down different approaches to setting and working on NHS priorities. Approaches to the role of primary care and the degree of diversity of provision and contestability encouraged or allowed differ across the four countries. Generally, diversity of
provision is far higher up on the policy agenda in England than in the other countries\(^8\). Although *Our National Health: A plan for action, a plan for change* (Scottish Executive Health Department, 2000) identified that spare capacity within the independent sector could be used to address waiting-list problems within the NHS, there appear to be no long-term plans to involve the private sector to the same extent in Scotland. A similar approach to that in Scotland exists in Northern Ireland (though since the suspension of the Northern Ireland Assembly in 2002, no major changes in health policy affecting funding or the primary care sector have emerged) and Wales (Galloway, 2004).

English policy differs from the other three countries in the degree to which it looks to increased separation of commissioning and provision of services to provide the advantages of efficiency and responsiveness to patient needs. This, in turn, may mean that opportunities for nurse entrepreneurship in the provision of primary care services are greatest in England.

### 3.3 The policy context for entrepreneurialism in the UK

Overall government policy has influenced health policy in two ways. Firstly, cross-cutting reviews have incentivised all government departments to prioritise certain goals. Secondly, it has set the overarching context of the government’s approach to enterprise and the encouragement of entrepreneurial behaviour as part of its overall social policy.

In terms of departmental targets, as part of its spending reviews in 2002 (renewed in subsequent years), the Treasury set up a range of performance targets for all government departments. The Department of Health was set 12 targets in 2002 concerning speed of access to various services and increased choice regarding hospital appointments as well as a number of disease-focused targets. Although some of the documented claims to have achieved such targets appear incomplete and occasionally unconvincing (see, for example, http://www.hm-treasury.gov.uk/performance/targets/perf_target_13.cfm), such performance monitoring has clearly had a strong influence on priorities within the department, as our review will show.

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\(^8\)The Secretary of State for Scotland published the White Paper *Designed to Care; Renewing the National Health Service in Scotland* in 1997 (The Scottish Office, 1997). As a result of the document *Our National Health*, published in December 2000, all NHS trusts in Scotland were abolished. *Improving Health in Wales* was launched in February 2001 and was the equivalent of the *NHS Plan* in England.

There are no PCTs in Wales, instead resources are allocated to 22 health boards for commissioning health care, along with secondary care commissioning groupings. Commentators believe that the role of the independent sector in providing services in Wales will be less that that in England. A similar picture exists in Scotland where 15 NHS boards fund both primary and secondary care sectors.
Government policy has attempted to promote aspects of entrepreneurial behaviour as one element of its approach to addressing social problems, such as inequality and exclusion, and to add flexibility to some health and social services traditionally delivered by state agencies. In 2002, the Chief Secretary to the Treasury and the Home Secretary launched the report of the Treasury’s cross-cutting review of the role of the voluntary and community sector in service delivery (Her Majesty’s Treasury, 2002). The report set out recommendations designed to overcome the barriers facing voluntary and community organisations in delivering public services and to facilitate partnerships between the government and the voluntary and community sector. The report highlighted the potential of the contribution of social enterprise.

A unified Social Enterprise Strategy was launched and the Social Enterprise Unit at the Department of Trade and Industry was charged to co-ordinate its implementation. Four years later, Our health, our care, our say: a new direction for community services, the white paper on health and social care published by the Department of Health on 30 January 2006, contained some significant commitments to social enterprise. In particular, it set out the creation of a new Social Enterprise Unit within the Department of Health and indicated that a fund would be set up to ‘... provide advice to social entrepreneurs who want to develop new models to deliver health and social care services. This fund will also address the problems of start-up, as well as current barriers to entry around access to finance, risk and skills, to develop viable business models ... support people developing new social enterprises delivery models.’ (Department of Health, 2006). This initiative was welcomed by the Social Enterprise Coalition, a body that promotes social enterprise in the UK. This move can also be understood as following on from a wider cross-government policy agenda for the public services coherent with the development of ideas that began with McLaughlin et al. (2002) for the incorporation of private sector ideas and methods into public services, as is common in many other European countries (Saltman et al., 2002).

3.4 Key health policies and events

Table 3 gives an outline of recent health policies and events that are relevant to this scooping exercise.
Table 3 Selective chronology of key health policies and events relevant to NMHV entrepreneurs and patient choice

<table>
<thead>
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<th>Year</th>
<th>Event</th>
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| 1997 | **The new NHS, modern, dependable** (Department of Health, 1997a) published in England sets out the need for more flexible professional roles and ways of working within the NHS. **The NHS (Primary Care Act) 1997** Introduction of flexibility through:  
  - Salaried GPs  
  - Primary medical service (PMS) contracts between practices and health authorities to improve personal medical services within case-limited general medical service (GMS) budgets  
  - PMS plus contracts to extend the PMS pilots to cover personal medical services and a range of other services under a combined GMS/hospital and community health services budget and salaried GPs  
  - GP fund-holding is suspended but the purchaser-provider split is retained |
| 1998 | **NHS Direct is launched in England**  
*Our healthier nation. A contract for health* is published by the Department of Health  
*Working together for a healthier Scotland* is published by the Scottish Office Department of Health (see also 1999)  
*Better health. Better Wales* is published by the Welsh Office  
The English document set health targets for the next 10 years and, acknowledging the influence of adverse social, economic and environmental factors as causes of ill-health, promised action across government departments to tackle poor housing, low wages, unemployment, crime and air pollution |
| 1999 | **1999 Health Act**  
This English act:  
- replaced the fund-holding scheme introduced in 1990 with primary care groups, each group to cover a population of about 100,000  
- established a Commission for Health Improvement to provide independent scrutiny of the standards of clinical care  
- made provision for payments between health service bodies and local authorities  
- conferred powers to regulate any profession concerned with the physical or mental health of individuals  
- Part II of the act dealt with changes to the NHS in Scotland  
Primary care groups introduced in England on 1 April; 92 first-wave PMS pilots launched. Policy changed about the presence of nurses on the boards of directors of these and successor bodies  
The Secretary of State for Health (England) announced the opening of NHS walk-in centres. In most cases the care available would be given by a nurse. The British Medical Association called for the clinics to be |
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<tr>
<td>1999</td>
<td>Run as pilot schemes and for their work to be evaluated</td>
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<tr>
<td>2000</td>
<td>The NHS Plan: A plan for investment, a plan for reform is published by the Department of Health</td>
</tr>
<tr>
<td>2002</td>
<td>Delivering the NHS plan: Next steps on investment, next steps on reform is published by the Department of Health</td>
</tr>
<tr>
<td>2003</td>
<td>Building on the best: Choice, responsiveness and equity in the NHS is published by the Department of Health in England.</td>
</tr>
<tr>
<td>2004</td>
<td>The NHS improvement plan: Putting people at the heart of public services is published by the Department of Health</td>
</tr>
<tr>
<td>2005</td>
<td>Commissioning a patient-led NHS is published by the Department of Health</td>
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_Making a difference: Strengthening the nursing, midwifery and health visiting contribution to health and healthcare_ is published by the Department of Health

- New nursing strategy: 10 key roles for nurses. Plans for nurse consultants first outlined

- Health service reform continues with continued emphasis on flexible NMHV roles

- The first wave of PCTs go live. Independent nurse prescribers permitted to prescribed from a limited formulary

- PCTs to be free to purchase care from the most appropriate provider (public, private or voluntary)

- Financial flows to change: cash for treatment to follow patients to enable choice of provider

- Choice of hospital and other providers high on its agenda, with use of private facilities made possible in order to achieve this

- New PMS contract agreed

  From 1 April, PMS arrangements change, so increasing the flexibility of PMS

  Additional contractual mechanisms beyond new GMS and PMS guidance produced and change of statutory direction made:

  - Specialist PMS providers (new model within PMS not expected to deliver totality of essential PCMS)
  - Alternative primary medical services (APMS) contracts
  - Primary Care Trust Medical Services (PCTMS) contracts

- This document follows on from the publication of _Creating a patient-led NHS_ in March 2005 and focuses on how the Department of Health will develop commissioning throughout the NHS, with some changes in
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|      | function for PCTs and strategic health authorities (SHAs)  
The Third Sector Commission Taskforce is set up to promote the use of the voluntary sector in healthcare provision |
| 2006 | **Our health, our care, our say: A new direction for community services** is published by the Department of Health  
This continues the work on patient choice and sets out mechanisms for delivering more personalised health services. It sets out some nurse-led innovative services and various measures to encourage social enterprise to engage with the delivery of health and social services |

### 3.5 Overall policy priorities for the NHS since 1997 and ‘New Labour’

We first consider the thrust of UK health policy with respect to setting the context and preparing the way for the subsequent emergence of the promotion of NMHV entrepreneurialism. The promotion of innovation has been a prominent way in which this context has been set and nursing has been a particular target for this message.

#### 3.5.1 Reducing waiting lists and increasing throughput

‘New Labour’ was elected in 1997 with pledges to dismantle the NHS internal market and spend the savings on reducing waiting lists. By December of that year *The New NHS: Modern, Dependable* (Department of Health, 1997a) was published, adding the establishment of national standards of treatment and a programme of NHS modernisation to this ambition.

#### 3.5.2 ‘Modernisation’ of working practices

In this and subsequent policy, ‘modernisation’ is presented as the development of more flexible ways of working, both in terms of hours and of roles. The breaking of professional demarcations, leading to innovative ways of working, becomes a central feature in subsequent policy where innovation is explicitly encouraged.

*The NHS plan: A plan for investment, a plan for reform* (Department of Health, 2000) and *Making a difference: Strengthening the nursing, midwifery and health visiting contribution to health and healthcare* (Department of Health, 1999a) set out changes that are said to have ‘put nurses at the heart of the modernisation agenda’. ‘Old’ demarcations, and the rigid ways of thinking that the NHS plan associates with them, are described as preventing nurses from achieving their potential. If nurses were and continue to be given
prominence, it could be because the government realised that doctors were among the fiercest resisters of such ‘modernisation’ if it means submitting to increasing managerial control (Munro, 2002). Other initiatives and legislation, such as the New Deal for Junior Doctors in 1991 and the European Working Time Directive, which came into effect for doctors in training in August 2004, have also acted as drivers for nurses to move into previously medical roles. Aspirations for greater professional status may also add to the attractiveness of nurses taking on these roles, with certain activities, such as prescribing, having particular symbolic function. In addition, nurses publicly identify with the humanity and quality of the patient experience (McTavish, 2003; Chapple et al., 1999) and might be expected to initiate or participate in initiatives that may improve this.

‘Modernisation’ presents certain organisational advantages because the breaking down traditional demarcations can make patient flows more efficient and play a part in managing demand for highly stretched parts of the service. For example, the nurse-led NHS Direct is described as diverting demand from conventional NHS services. The chief nursing officer’s 10 new roles for nurses, included in the NHS plan, feature organisational/administrative roles alongside clinical roles, for example ordering tests, managing case loads, prescribing drugs. In 2000 and 2001, when patient waiting lists and their manipulation by some trusts were a high-profile political problem (Carvel and Allison, 2001), The NHS Plan: An action guide for nurses, midwives and health visitors (Department of Health, 2001a) emphasises that new nursing roles can improve patients’ journeys through the health care system. Nurses can reduce waiting times and aid access to the system by providing additional points of access.

3.5.3 ‘Patient choice’

Patient choice has come to the fore of the government’s priorities for the NHS. According to the NHS Confederation, policy priorities since The NHS Plan: A plan for investment, a plan for reform (Department of Health, 2000) can be seen in terms of two phases9. During 2003–2006 policy priorities feature improving access and reducing waiting times; during 2004–2008 this shifts to increasing patient choice and the range of providers (Miles, 2005). The Department of Health’s policy and guidance website states that:

9In some specific areas of health care this policy agenda on increasing user choice has a longer history. ‘Choice’, along with continuity of care(r) and control, has been a central theme in maternity care policy from the early 1990s (Department of Health, 1993). Such policy had been influenced by a decade or more of campaigning by user groups, e.g. the Association for Improvements in the Maternity Services and the National Childbirth Trust, and by midwifery organisations, e.g. the Association of Radical Midwives, to offer ‘woman-centred’ alternatives to the bio-medical model of maternity midwifery care (Leap, 1996).
‘People will be able to access primary care services in more flexible ways such as walk in centres at train stations or football stadiums. Primary care practices will be able to offer a wider range of services such as diagnostics.’
(www.dh.gov.uk/PolicyAndGuidance/PatientChoice/Choice/fs/en)

Building on the Best: Choice, Responsiveness and Equity in the NHS was published in 2003. This set out the intention to offer patients choice at the time their GP refers them for treatment. By offering choice at this point, patients would be given the chance to choose the hospital that best suited their needs. A £65 million contract to provide all GPs with the ability to make outpatient appointments electronically was to facilitate this (Rivett, 2006). However this level of choice could lead to problems in ensuring that financial limits were not exceeded at a local level. In addition, it would be managers and clinicians who would retain control of how far patients would be offered new options, and, crucially, the capacity of the NHS to provide services might constrain choice for practical reasons. Nevertheless, as part of the NHS improvement plan (Department of Health, 2004a), PCTs were instructed to offer their patients 4–5 choices regarding where they might receive treatment; private/independent care was to feature in these choices. The publication of Creating a patient-led NHS (Department of Health, 2005a) allowed independent providers, such as BUPA, to be included in the list of choices. The paper also proposed the creation of regional or national contracts with providers to reduce the transaction costs of multiple contracts. This arrangement was implemented in January 2006. However, choice presents problems: ‘It was possible that patients would increasingly choose private-sector hospitals. Many people thought they were cleaner, better managed, had shorter waiting times and provided better facilities. If money followed into private hospitals, there was a substantial threat to the budget of NHS ones’ (Rivett, 2006).

Patient choice is also presented as the driver for flexibility and innovation in The NHS improvement plan: Putting people at the heart of public services (Department of Health, 2004a), which claims that ‘front-line’ staff are being incentivised to be ‘innovative and creative’. ‘A new spirit of innovation has emerged’, claims the then Secretary of State for Health, John Reid, in the foreword. Although much of the claims about progress are focused on reduced waiting times, access and choice are also emphasised. ‘Working flexibly’ is connected to ‘responding to patients’ needs’. Patient choice is described in terms of ‘personalised care’ and choice of different providers, which from 2008 can include non-NHS providers. This is said to help with both capacity problems and choice: ‘Patient choice will be the key driver of the system’. The practice nurse, NHS Direct and walk-in centres are seen as the elements of choice that a patient may have as alternatives to making an appointment to see a GP. It is envisaged that the new community matrons (discussed on page 41 of The NHS Improvement Plan: Putting people at the heart of public services, Department of Health, 2004a) will manage the cases of people with complex needs.
Despite this promotion, a recent review has found that choice is not a high priority for many NHS patients, partly because there has been little real opportunity to exercise such choice to date (Fotaki et al., 2005).

### 3.6 Changes in primary care

#### 3.6.1 PMS pilots

The unanticipated interest in GP fund-holding, introduced as a mechanism of the internal market in the early 1990s, has shown governments the potential of primary care to lead aspects of NHS reform. It is in this sector that policy can be understood as explicitly enabling entrepreneurial activity. The 1999 PMS pilots were presented by the chief nursing officer (Department of Health, 1999a) as innovative and sometimes status-reversing examples of new forms of provision in this sector. Each of the examples given in Making a difference, strengthening the nursing, midwifery and health visiting contribution to health and healthcare (Department of Health, 1999a) is linked in the document with some improvement for patients. These innovations took the form of either role substitution or the provision of services to previously neglected groups, such as pregnant drug users.

#### 3.6.2 How policy reframes and promotes desirable qualities in the nursing workforce

In 2000, the chief nursing officer published Making a difference in primary care: the challenge for nurses, midwives and health visitors – Case studies from NHS regional conferences (Department of Health, 2001b). Many, if not all, of the case studies chosen emphasise personal features of nurses that are virtually identical to those said to characterise social entrepreneurs (see Section 3):

- risk-taking
- networking
- tenacity
- vision
- working with particular (often disadvantaged) communities
- seeing a need for grass-roots action
- having to argue for resources and funding.

These individuals are differ, however, from most conceptions of social entrepreneurs in that they are still enmeshed in bureaucratic NHS structures. Furthermore, according to their own accounts, there is sometimes tension between NHS bureaucracy and their innovative work (although such ‘intrapreneurship’ is a widely discussed concept often promoted as an aid to organisational innovation [Pinchot, 1985]).
3.6.3 The focus on primary care: contestability and confusion

PCTs, which were established in April 2000, succeeded primary care groups and were given significant responsibilities and budget (80% of the NHS budget) to commission services for their localities. Since their creation, and direct allocation of budgets in 2002, PCTs have been increasingly encouraged to diversify their commissioning of care into the voluntary and independent sectors. The NHS Improvement Plan: Putting people at the heart of Public Services (Department of Health, 2004a) enabled PCTs to commission services from a wider range of providers, with a target of 15% of services provided from the independent sector. Opening up diversity in providers – including the private sector – of services for NHS patients was originally looked to as a way of meeting ambitious waiting-list targets without having to first develop capacity within the NHS itself, which would clearly take time. However, subsequent policy appeared to go a step further. The involvement of the private sector, having started out as a short-term necessity, is now regarded as a policy end in its own right. As the Department of Health has stated: ‘It is an explicit objective of government health policy to shift towards greater plurality and diversity in the delivery of elective services’ (Lewis, 2002). In fact, diversity of provider, funding source and of service design has been promoted as a mechanism for increasing choice (Department of Health, 2000; Department of Health, 2003; Department of Health, 2004b). Fotaki and colleagues claim that while there may not be strong demand from patients for choice, from the policy-maker’s point of view, the introduction of choice may have other attractions, for example as a means of introducing contestability into a service with the presumed effect of focusing providers attention on quality of service issues (Fotaki et al., 2005).

During this scoping exercise the question of the future of PCTs as providers of primary care services became a policy controversy. In March 2005, the Department of Health introduced a policy reform detailed in Creating a patient-led NHS: Delivering the NHS improvement plan (Department of Health, 2005a). Among its proposals were plans to encourage the primary and community sector to develop new services and practices. On 28 July 2005, NHS Chief Executive Sir Nigel Crisp, published a letter to, among others, Chief Executives of NHS organisations and PCT chairs, which set out the impact that these reforms would have on commissioning of services within the NHS (Department of Health, 2005b), in which he stated:

‘As PCTs focus on promoting health and commissioning services, arrangements should be made to secure services from a range of providers – rather than just through direct provision by the PCT. This will bring a degree of contestability to community-based services, with a greater variety of service offerings and responsiveness to patient needs. … the direction of travel is clear: PCTs will become patient-led and commissioning-led organisations with their role in provision reduced to a
As one step along this direction of travel, a national scheme launched in July 2005, The Innovation in Primary Care Contracting programme, incentivises the uptake of APMS contracts on the part of PCTs. PCTs are to be supported to engage in contracts with alternative service providers in order to offer previously unsupplied services within particular, often deprived, communities. The scheme provides legal and other support to encourage contracting with new types of organisation or to develop new types of contract with ‘entrepreneurial GPs and other primary care providers, including those from the independent and voluntary sectors’. In Section 4.5 we introduce a model developed by Burchardt and colleagues (1999) that has been used to categorise the various combinations of ways in which health care services can be commissioned, provided and delivered.

Responses from the nursing profession to the changes in primary care have been mixed. While the RCN has campaigned against this change on the grounds that it would fragment patient care services and lead to adverse selection and other ethical problems associated with private provision, news articles have featured some stories of the formation of nurse-led independent service providers as generally positive examples of nurses’ entrepreneurial abilities (Anon, 2005a). Fotaki and colleagues (2005) also caution that the introduction of choice policies can, when combined with greater access to performance data, have hidden adverse effects on equity. For example, providers may try to avoid treating high-risk, sicker patients in order to improve their own performance figures. One of the knowledge gaps they identify is whether choice policy actually does lead to contestability in the long run and what conditions best facilitate it.

3.6.4 New nursing roles: new nursing flexibility

One explicit link between the new expectations of nursing roles and the concept of entrepreneurialism came in the form of the then Health Secretary, John Reid’s, first address to the Chief Nursing Officer’s Conference in November 2003 (Department of Health, 2003). It is considered here because its argument in favour of flexible health care roles in terms of entrepreneurialism and its association with patient choice can be seen as representing the blurring of these two ideas in health policy as a whole. The press release (Department of Health, 2003) and the full text (The Guardian, 2003) of the speech show the mixing of a number of ideas:

• recent policy has added new opportunities for nurses
• nurses as doctor substitutes/advanced practitioners/gaining new skills
• nurses as autonomous practitioners
• nurses not confined by role
Entrepreneurs are defined as risk-takers and innovators but no examples are given of nurses in risk-taking roles. Instead, a picture is given of nursing responding to the needs of individual patients, which is followed by a discussion of substituted roles. That these themes are drawn together more by association than by clear argument suggests a possible lack of clarity and precision in the government’s promotion of entrepreneurialism in nursing. This can also be seen as an example of the positive associations of the term ‘entrepreneurial’ being used to encourage nurses to be more receptive to organisational and role flexibility, a major aim of health policy at the time. This particular speech also draws attention to the recent policy emphasis on patient choice. Nurses and midwives are described as playing a vital role in promoting choice, however, this is through role substitution rather than entrepreneurial ventures. The example given, as with most of the policy documents reviewed, concerns the increased ease in the patient pathway that can result from increased role flexibility, in this case it is the substitution of nurse prescribers for doctors.

The Chief Nursing Officer’s December 2003/January 2004 Bulletin features her response to John Reid’s speech (Department of Health, 2004c). Already it is clear that, at times, the term ‘entrepreneur’ is used as a synonym for innovator and partly functions to re-emphasise extended roles or role substitution (again, the example given is nurse prescribing). The Chief Nursing Officer’s published response echoes the need for initiative and problem-solving among nurses. In summary, the Health Secretary’s speech and the response from the Chief Nursing Officer appear at face value as important statements aimed at encouraging and enabling nurse entrepreneurship. However, their content can be more easily understood as reinforcing the already existing policy concerned with the creation of a more flexible NHS workforce and the breaking down of traditional professional boundaries.

Given the promotion of new roles for nurses by the Department of Health as symbolic and status-enhancing, it is not surprising that some opposition has been voiced within the medical profession. Although, generally, medics appeared to have acquiesced to the establishment and gradual expansion of nurse prescribing, one response from Richard Horton in the Lancet in 2002 can be seen as both contributing to professional protectionism and articulating insightful political analysis:

‘the UK will be embarking on a dangerous uncontrolled experiment … Nurses are being manipulated, under the guise of providing quicker and more efficient access to health care to fill the gaps left by too few doctors … Prescribing is not a major advance in
professional status for nurses. It is merely redrawing the boundaries of a profession to serve an acute political problem, with little regard for the impact it will have either on nursing or the care of patients.’ (The Guardian, 2002).

3.7 Other policy strands

Other strands of policy where there is a link between entrepreneurialism and choice are found within policy concerning midwifery, though their history is longer and found a particular articulation in Changing Childbirth (Department of Health, 1993). The Independent Midwives Association’s NHS Community Midwifery Model, currently being considered by the Department of Health, provides an example of an alternative model of care to that which is traditionally provided (the model is outlined in full on the Independent Midwives Association’s website [www.independentmidwives.org.uk]). Under this model of care, the pregnant women chooses a midwife from a list of local practitioners and builds a relationship with her during the course of her pregnancy. The midwife would have access to NHS facilities, so her client could choose the place and type of birth most suited to her needs. It is proposed by the Independent Midwives Association that this model sit alongside current provision and be available to any midwife interested in working in this way and to women who want continuity of care.

A number of other policy initiatives have addressed health inequalities by encouraging entrepreneurial activity around service provision to previously unserved or under-served groups. Often the intention has been that entrepreneurial activity would promote equity and increase access by extending choice beyond those sections of the population who are affluent and/or articulate. There are social programmes that address inequalities in ‘collectivities’ or communities, such as the development of Sure Start and children’s centres and Healthy Cities and Health Action Zones. In terms of policy, Sang (2004) believes policy on choice has presented the opportunity to rethink roles and contributions in relation to health services and to understand the purpose of social and ‘civic’ entrepreneurs as challenging health inequalities. However, this policy also, perhaps necessarily, raises other questions (many articulated by Fotaki et al., 2005), such as: How does improved equity and access fit with greater organisational effectiveness and efficiency? Will some patients continue to be able to make ‘better’ choices than others because of education, income or social position? Oliver and Evans (2005) argue that there are few safeguards against this risk at present. On the other hand, there are examples of where social entrepreneurship can encourage community involvement in health care by presenting the opportunity for increased local democracy and democracy in health (Fawcett and South, 2005).
3.8 Conclusion

Since 2001, policy has emphasised patient choice as a priority value within the NHS. It has encouraged innovation and entrepreneurialism as likely to promote patient choice within, and on the edges of, the NHS. Recent, accelerating, and sometimes apparently unconsidered changes to primary care services, have attempted to promote diversity of provider. As a result of changes already implemented there are some examples of NMHVs acting entrepreneurially by providing services to PCTs that were previously provided within the NHS (e.g. Anon, 2005; Houghton, 2002), though it is not clear whether these initiatives necessarily promote patient choice.

A second way that entrepreneurialism has appeared in policy is as a synonym for innovation as part of the promotion of desirable qualities within the NMHV workforce, which may broadly be termed intrapreneurial. The then Health Secretary John Reid’s speech, discussed above, and earlier documents encouraged NMHVs to move away from stereotypical roles, which are said to feature passivity, a rule-bound mentality and subservience to doctors. Such talk can raise energy levels and have an effect on culture and consciousness among NMHVs, quite apart from any enabling policy or organisational changes. However, certain initiatives (e.g. nurse prescribing and NHS Direct) show that this kind of policy, coupled with any necessary legislative change, has the potential both to address issues of organisational efficiency and demand for NHS services and to be generally attractive to the NMHV professions, though, predictably perhaps, it is less appealing to doctors in certain cases.

Finally, various scenarios of the contribution that entrepreneurial activity can make to patient choice emerge from this review:

- Alternative providers
- Organisational effectiveness
- Different models of care
- Increased service provision to unserved or under-served groups

In the next section we detail and provide categorisations of NMHV entrepreneurial activity.
Section 4 Nurses, midwives, health visitors and entrepreneurship: The evidence

4.1 Introduction

This section considers the evidence for NMHV entrepreneurship, firstly from the international then the UK perspective. In each of these sections, we consider:

- Specific evidence of the extent and types of entrepreneurship undertaken by NMHVs.
- Evidence of the circumstances, triggers, aspirations and barriers to the different types of entrepreneurship by NMHVs.
- Evidence of the outcomes and consequences of entrepreneurship by NMHVs.

This scoping study has examined a wide range of literature. Before discussing this in detail, a number of issues need to be raised about the nature of this literature. It should be first noted that the volume of international empirically based literature on this topic is very small, suggesting that many aspects have not been objectively examined. The narrative and descriptive accounts by entrepreneurial nurses are more common but are not extensive. In part, this is a result of the nature of the entrepreneurial person and how they view themselves, as pointed out by members of the expert seminar: “We ‘do’: we don’t write it up”. It should be noted, however, that some narrative accounts can also be read as a marketing or promotion exercise, as with some of the journalist-written and feature articles. Individual websites, while they may feature a range of items e.g. career history, are also primarily designed to market the nurse entrepreneur’s services. It is also noticeable that some accounts, particularly those by journalists, are presented as a ‘hero’ type story: the individual setting out against great challenges, where no one of the same group has gone before, and reporting back success and path finding for others. Like hero stories, these can be read as seeking to inspire others and hence they do not recount failure. Such accounts relating to entrepreneurial activities of NMHV mostly present elements of the journey, rather than the endpoint of return to tell the whole story.

An additional challenge presents itself in reading the international literature related to nurses and midwives: not only are there a variety of interpretations of the noun, ‘entrepreneur’ and adverb, ‘entrepreneurial’, across and within different cultures, as noted in Section 3, but the term ‘nurse entrepreneur’ has been defined in different ways. For example, the International Council of Nursing (a
federation of 130 national nurses' associations) states that the definition of nurse entrepreneur is 'a proprietor of a business that offers nursing services' Sanders (2003, p4) while other nursing organisations offer statements such as 'nurse control of practice and patient care' (Riesch, 1992). In addition to this variety, there are some terms relating to nurses that have different interpretations according to the specific country and health system. These include, 'independent nurse', 'independent midwife', 'independent practice nurse' and 'private practice nurse'. In many countries, such as Norway, New Zealand, Australia and the USA, the term 'independent nurse' refers to self-employed nurses, as does the term 'independent midwife' in the UK. However, the term 'independent nurse' is also used to refer to behaviours associated with autonomy and self-governance while working within a public health system, for example the UK independent nurse prescribers practice within the public health sector as employees. The term 'independent sector nurse' has been translated from German and refers exclusively to self-employed nurses. In the USA, the term 'independent nurse contractor' is used to denote 'nurses who practise outside the customary role of employee' electing to contract and negotiate directly with health care facilities, such as hospital, nursing homes, doctors’ offices, while still providing clinical care. Equally these nurse contractors elect whether they will work as sole proprietors, limited liability companies or in partnerships using a variety of legal entities (for examples, see http://www.independentrncontractor.com/). In the UK, however, the term 'independent nurse contractor' is not used exclusively for self-employed nurses but also includes nurses employed outside of the NHS in private hospitals, hospices and care homes. 'Private practice nurse' is a term used in the USA specifically to describe nurses employed in doctors’ private practice offices, while in Australia it refers to self-employed nurses offering clinical specialist skills. Bearing these caveats in mind, we now turn to the evidence from the scoping exercise.

4.2 Overview of the literature examined

Of 462 articles initially identified from our electronic and hand searches, 143 met the inclusion criteria (see Section 1). A total of 104 published papers described UK entrepreneurial activity among NMHVs. Beyond this was additional grey literature. As just one illustrative example, we found 119 articles dealing with UK entrepreneurial activity among NMHVs in primary care settings alone.

The electronic scoping through e-list networks (see Section 1.3.2) resulted in 38 responses. No additional evaluative literature was identified but respondents supplied additional accounts from 21 independent nurse and midwifery consultancies, 4 acute care sector setting and 3 primary care setting nurse-led ‘intrapreneurial’ initiatives.
4.3 The international perspective

Different health care systems and changes in the health care environment create varying opportunities for nurse intra- and entrepreneurship. It is noted that internationally a wide range of intrapreneurial activities by nurses exist, as indicated by the International Council of Nurses (ICN) Innovations Database (http://www.icn.ch/innovations/), which was launched in May 2005 to encourage and support the global dissemination of ideas. Within the scope of this review it has not been possible to investigate intrapreneurialism internationally, and hence Section 4.4.2 focuses on the self-employed and business owners.

4.3.1 The extent of nurse and midwifery entrepreneurs internationally

The ICN estimates that, in general, 0.5–1% of registered practising nurses are nurse entrepreneurs (Sanders, 2003), although no supporting evidence is cited. It is difficult to establish with any accuracy the number or the growth trajectory of nurses acting entrepreneurially either within or outside of health care organisations. The reasons include: the variety of definitions (as noted above and in Section 2); the lack of regulatory frameworks in all countries to establish the criteria for the use of the title ‘nurse’ or ‘nurse midwife’; the inconsistent data collection/monitoring of nurses and midwives and their activities. The following provides an overview of evidence for the extent of nurse entrepreneurs, identified through the database search and the web-based search of public access international and national nursing organisations. This provides a limited view and it is suggested that a more accurate picture would only be obtained by systematically investigating within each country/region and with the support of nursing organisations and government offices concerned with health systems.

The USA has a health care system where nurse entrepreneurs might be expected to be found in large numbers. While 2.8 million nurses are registered to practise, there is little information on entrepreneurial activities provided by any of the US professional nursing organisations. An independent association, the National Nurses in Business Association, estimates that across all the states there are approximately 5000 (0.18%) registered practising nurses who are self-employed (http://www.nnba.net/). A range of activities, which is by no means exhaustive, is given including: ambulatory care, cardiac rehabilitation, case management, nephrology, travel health, education and training, forensics, genetic counselling, infection control, etc. Other exemplars documented in the literature include: nurse consultation services (Porter-O’Grady, 2001; Schulmeister, 1999); registered nurse first assistant practice (DeFrancesco, 2004); a specialist addiction outreach service (Anon, 1999); independent nurse practitioners in orthopaedic care; private nursing and education
(Elabdi, 1996); an advanced practice nurse-owned community wellness centre (Bartel and Buturusis, 2000); and a perinatal home care service (Eaton, 1994).

The ICN focused on self-employed nurses as part of a recent Workforce Report (German Nurses Association, 2005). It noted that, from the nine contributing nursing associations, the numbers were very small, giving the following specific examples:

- **Germany** – approximately 800 nurse business owners (mainly of community nursing services) are represented by the Deutsche Berufsverband für Pflegeberuf (German Nurses Association). In addition, the association reports the provision of business counselling services to an unspecified number of other nurses who choose to work independently.

- **New Zealand** – the New Zealand Nurses Organisation estimates that 50 (0.1%) of the total number of registered working nurses are practising independently, with the largest group being occupational health nurses.

- **Norway** – the Norwegian Nurses Association identified that an ‘increasing number of nurses who have their own business enterprises selling nursing services’; however the number is unspecified.

- **France** – 15% of working registered nurses practise in a self-employed capacity. This is in part due to the historical legal protection of the Infirmière Libérale Française (independent nurse contractors who provide clinical care principally in the home). It is noted that under French legislation, other nurse-owned businesses, such as nurse consultancies or nursing workforce providers, are not recognised as nursing practices, therefore it is suggested that the numbers of independent nurses (nurse entrepreneurs) could be much higher (Sanders, 2003).

The available information on midwives would also suggest variations in different health care systems. For example, self-employment is common in the maternity care workforce in the Netherlands. Statistics from the Dutch Ministry of Health for January 2004 indicate that at that time there were 1940 active midwives, of whom 64% were working in their own practices – the majority of these were in group practices. (Poorter, 2005). Likewise in New Zealand, there are large numbers of self-employed midwives, with 50% of all midwives being self-employed and 50% being employed (New Zealand College of Midwives, see http://www.midwife.org.nz/); there were 3780 active midwives in New Zealand in 2004 (New Zealand Health Workforce Statistics, 2004 www.nzhis.govt./stats/nursestats). Contrastingly, the number of self-employed midwives in Australia is small. It is reported that there are only 60, although not all of these midwives are in full-time practice (personal correspondence with Robinson, an independent midwife practitioner, who is the national coordinator of the Australian Society of Independent Midwives [www.midwiferyeducation.com.au]).
In developing countries, most of the more detailed studies concerned with private sector health care provision relate to the activities of doctors. Far less is documented about the extent of entrepreneurial activity among other health care practitioners, such as nurses and midwives. Even in a country with relatively sophisticated data sources, such as South Africa, the number and distribution of nurses working in the private sector are hard to ascertain as the South African Nursing Council does not collect this information (MacDonagh et al., 2003). However, some small-scale exploratory studies and evaluations indicate that independent nursing and maternity ‘homes’ or practices exist in many settings in Africa including: Ghana (McGinn et al., 1990, Obuobi et al., 1999), Uganda (Seiber and Robinson-Miller, 2004), Kenya (Yumkella and Githiori, 2000), Tanzania (Rolfe et al., undated), as well as in the Philippines (John Snow Inc, 2005) and in Indonesia (Geefhuysen, 1999).

4.3.2 Other indicators of NMHV entrepreneurial activity

Another indicator of the level of nursing and midwifery entrepreneurs is the amount of support requested from national nursing organisations, nurse entrepreneur networks and education courses/curricula for nurse entrepreneurship.

We have identified guidance publications from the ICN and three national nursing organisations, including the UK (see Section 4.4).

The ICN first published guidelines on the ‘Nurse entre/intrapreneur providing nursing service’ in 1994 and updated this in 2003 (Sanders, 2003). It provides an overview of the types of entrepreneurial practice and gives specific advice to nurse entrepreneurs providing direct nursing services on roles and legal, economic and ethical issues. It also advocates that national nursing associations should play a significant role in the development and regulation of nurse entrepreneurs.

The Canadian Nurses Association published a short paper entitled ‘On your own – the nurse entrepreneur’ (CAN Canadian Nurses Association, 1996). This paper provided a resource for Canadian nurses wishing to pursue entrepreneurial nursing practices, and described the processes and professional and business considerations that would be required in Canada.

The Sigma Theta Tau International Honor Society of Nursing in the USA, published one paper providing advice and information for nurses considering the move from traditional patient care to a career as an entrepreneur (Hieronymus and Geil, 2006).

We have been able to identify networks specifically aimed at nurses in enterprise in three countries, including the UK (see Section 4.4), and one for independent midwives in developing countries. In Australia, Nurses in Business is a members-only network formed within the
Royal College of Nursing, Australia (numbers unknown). In the USA we have identified three online national networks:

- The National Nurses in Business Association, Inc was founded in 1985. This membership organisation provides information and creates new career opportunities for nurses working within intra- and entrepreneurial frameworks. It provides a range of educational, support and networking opportunities, conducts and monitors research related to nurse entrepreneurial activity and has established a nationwide database of nurse entrepreneurial activities (http://www.nnba.net).

- The National Association of Independent Nurses was founded in 2002. This is also a membership organisation. It represents the collective interests of independent contractors/independent nurses in business as opposed to nurse employees in traditional settings. It provides access to training materials and seminars, expert business advice and a members-only chat room (http://www.independentrn.com/).

- The Nurse Entrepreneur Network was launched in 2004 by a nurse/lifestyle coach. It is another membership organisation and offers an online facility for nurses to help other nurses build successful nursing businesses. It provides networking, educational and coaching opportunities and assists nurse entrepreneurs in forming collaborative alliances and promoting their services to each other and the general public (http://www.nurse-entrepreneur-network.com).

An additional American source of advice and support, which also provides online consultations on a range of legal and professional issues for would-be entrepreneurs, is the Medscape Nurses website (http://www.medscape.com). PSP-One, funded by United States Agency International Development (USAID), similarly runs a Midwives Exchange for midwives in private and independent practice in developing countries, which aims to assist independent midwives to ‘strengthen your practices, share your experiences, and learn what others are doing that works well’ (http://www.psp-one.com/section/technicalareas/quality/midwives).

In the USA (and UK, see Section 4.4.) we have been able to identify educational courses for nurses addressing entrepreneurship. The Health Science Center at the University of Tennessee is one example, using the concept of ‘nursepreneurs’ in its curriculum for advanced practice. It uses practicums (clinical training experiences) in entrepreneurial settings, such as the College of Nursing-owned Primary Care Practice enterprises, to model and teach relevant skills. The university cites individuals who go on to develop and start-up other nurse-owned nurse-managed businesses and collaborative partnerships (University of Tennessee, 2005).
4.3.3 International evidence for the drivers, triggers, aspirations and barriers to entrepreneurial activity by NMHVs

The wider literature on women and entrepreneurialism identifies that business opportunities and necessity are key reasons for undertaking entrepreneurial activity, accompanied by triggering factors such as the push and/or pull of personal, work and environmental circumstances (see Section 2). There are few international empirical studies of nurse entrepreneurs that can be used as comparisons for UK activity. We identified only six non-UK empirical studies focusing specifically on the motives and circumstances of NMHV entrepreneurial activity (the UK studies are reported in Section 4.4). One of these reports gave very little detail, making it difficult to assess its contribution (Amundsen et al., 2000). Another reported the preliminary testing of a new conceptual scale ‘entrepreneurial opportunity recognition’ with 128 members of the American National Nurses in Business Association (McCline et al., 2000) and suggested that the focus on entrepreneurial attitudes rather than on traits allowed the entrepreneurial act to be contingent on the situation and the individual.

The third study was from Tanzania. A recent nine-district study in Tanzania (Rolfe et al., submitted) identified retirement from public sector employment and fear of a slide into poverty as a major push factor for setting up private nursing and maternity homes. Pull factors are complex and include hoped-for economic rewards, flexible working hours, a sense of autonomy, the desire to use one’s talents and ‘not sit idle’, satisfaction in meeting the needs of under-served communities and the desire to maintain social standing through a professional identity.

Two of the studies came from Australia. Harris (2000) reports on independent midwifery and homebirth. In a trajectory similar to that of maternity care in the UK, the medical model has come to dominate maternity care in Australia and independent midwifery is seen as a challenge to the ways of working of the current system. The particular barriers to independent practice reported are the increase in the cost of professional indemnity (see also Robertson, 2002), the lack of government funding for midwifery care, and the lack of financially viable training opportunities. Wilson’s survey of 54 private practice nurses identified that important drivers included: job satisfaction, being able to use distinctive skills, making a difference to patient care, and enabling a return to nursing in line with other life activities. The nurses were reported not to have been pushed into private practice because they were unemployable, unable to find work or redundant. It was reported that private practice offered a better prospect than hospital-based work in this setting, as they placed value on autonomy and increased personal and work flexibility (Wilson et al., 2003).

The last report is of a US study based on interviews with four nurse entrepreneurs (Roggenkamp and White, 1998), which identifies...
personal motivating factors including financial rewards as well as freedom and flexibility. Instigating factors included “the nurses’ love of their particular field of nursing”. Identified barriers included a lack of business skills.

Similarly, a literature review of the types, advantages, barriers and implications of clinical nurse specialist entrepreneurs (with unspecified dates, inclusion criteria and countries) concluded that the key advantages reported were flexibility, freedom to focus on personal interests, quality and variety of work. The reported disadvantages included the higher cost of malpractice insurance, lack of hospital privileges, professional scepticism, start-up costs and lack of business acumen (Sao Lang, 2005). A second literature review explored the emerging role of oncology nurse practitioners in the USA (numbers unspecified) as partners in collaborative private practice (Bush and Watters, 2001). This review did not specify dates or inclusion criteria but was said to include other aspects such as personal experience. The authors concluded that major obstacles were: developing a supportive, collaborative relationship with oncology physicians in order to achieve shared care authority; limited/inconsistent prescriptive authority in different states; insurance reimbursement problems accompanied by lack of professional role recognition.

Within the international nursing organisation literature it is possible to identify that legislative change has had a direct impact on providing business opportunities for nurses. Examples for nursing and midwifery include:

- New Zealand – new health and safety legislation requiring organisations to perform health and hazard risk management, which created the business opportunity for occupational nurses to become self-employed and offer such a service (German Nurses Association, 2005).
- New Zealand – an act passed in 1990 permitting midwives to care for women without the involvement of an obstetrician or a GP has promoted the practice of independent midwifery (Fleming, 1996). Under this legislation the birth may take place at home or in a hospital. Furthermore, as from 1995, women in New Zealand have been able to choose their lead maternity caregiver and many are choosing independent midwives (Stimpson, 1996).
- Germany – introduction of long-term health insurance legislation in 1995 created the opportunity for nurses to become self-employed and provide home nursing care, to be purchased directly by the insured person (German Nurses Association, 2005).
- USA – legislative changes, such as the Balanced Budget Act (1997) and, more recently, the Medicaid Advanced Practice Nurses and Physician Assistants Access Act (2005) have provided new opportunities for advanced practice nurses/independent nurse practitioners, to provide health care services and get direct
reimbursement, independently of physicians. This has created the business opportunity but it is not clear to what extent this has been taken up (National Nurses in Business Association, undated).

- The Netherlands – the organisation of the insurance system, coupled with a law regulating health care fees, allow the government to control costs by specifying the rules of coverage and what will and will not be covered, which has protected the economic interests of the private midwifery practitioner (De Vries, 2005). For persons insured with health insurance funds, the health care insurer finances the costs of antenatal and perinatal care. The costs of an outpatient delivery (delivery room) in a hospital attended by a midwife and care by a gynaecologist are only reimbursed if there are medical indications. Until mid 2001 government protection and promotion of midwives practising independently was also assisted by a primaat – coverage rules that required primacy of midwives for women insured with health insurance funds. The Midwifery for Persons Insured with the Health Insurance Funds Decree stipulated that a GP would not be reimbursed for midwifery care provided by him or her if there was an active midwife under contract to the funds in the region10.

In developing countries, private sector provision of health care has also been encouraged in recent years as part of wider health sector reform programmes. There have been changes in government policies in a number of African countries (e.g. Tanzania, Zimbabwe, Uganda, Zambia) during the 1990s that have opened up the possibility of officially sanctioned private practice for nurses. However, the specifics of autonomous nursing and midwifery activities in the private sector have tended to receive relatively little attention from policy-makers and researchers (MacDonagh, et al., 2003). An exception is Indonesia, where great efforts were made during the 1990s to place ‘one midwife in every village’. Some 56,000 young midwives were trained and placed on 3-year contracts between 1991 and 1997; they were then encouraged to go into private practice to support themselves when that contract expired (Geefhuysen, 1999). However, sustainability has proved difficult in practice, and in 2002 the government tacitly abandoned its goal of midwife privatisation by allowing unlimited contract renewals for many government-funded midwives (Suk Mei Tan, 2005).

Private nurses and midwives associations exist in a number of developing countries. As international interest in public/private partnerships has increased, some have received technical assistance from USAID and other donor organisations in the areas of marketing

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10 On 11 June 2001, the Royal Netherlands Association of Midwives and the National Association of General Practitioners entered into a covenant containing agreements on mutual relationships and collaboration. Because of this, the primacy system could be allowed to lapse (Poorter, 2005).
and the creation of income-generation activities, management guidance, quality-improvement packages, and the establishment of group purchasing plans for family planning commodities (Abt Associates inc., 2005; Mantz, 1997; Private Sector Program, 2006). A variety of contracting and franchising arrangements are being tested. For example, the United Nations Children’s Fund (UNICEF) facilitated the creation of a Private Midwives Association in the Bari region of Somalia in 1997, and signed an agreement for the delivery of immunisation and other maternal and child health services, including the provision of antenatal care, through the association (UNICEF Somalia, 1997). In the Philippines, the USAID ‘Tango’ projects have supported the development and evaluation of a ‘social franchise’ model for family planning and maternal and child health services called the Well-Family Midwife Clinic (John Snow Inc, 2005).

Few of the empirical studies conducted outside the UK have discussed outcomes for patients as a result of services from nurse entrepreneurs. Those studies that do indicate that there can be obstacles to the provision of good-quality care and that access to certain types of service can be increased. Obuobi et al.’s (1999) study of private sector activity in Greater Accra, Ghana, for example, included focus group discussions with private midwives who worked in solo practice and operated maternity homes, averaging 12–15 deliveries per month. This group of midwives highlighted difficulties in gaining cooperation from government service providers for patient referrals. IntraHealth International’s (2005) evaluation of the PRIME II Project seems to indicate the value of offering specific new skills training to the private sector in some circumstances. An audit of client tracking forms at 94 facilities over 3 months indicated the impact of training 79 private and non-governmental organisation sector nurse–midwives and 22 clinical officers in post-abortion care. (Complications from unsafe abortion account for more than a third of all maternal mortality in Kenya.) This audit indicated that as a result of the initiative 1603 women with post-abortion complications were treated successfully with manual vacuum aspiration. In addition, 81% of the clients were counselled in family planning methods, with 56% accepting a method, and over half of the post-abortion care patients received counselling for prevention of HIV and other sexually transmitted diseases.

Harris (2000) looked at why women choose to give birth at home and why midwives work independently in Australia – a culture that does little to encourage these options. Mortality and morbidity rates in Australia and New Zealand, as well as in the Netherlands, England and the USA, were compared in the light of the various attitudes to homebirth and Harris concluded that homebirth is a safe option that should be supported by independent midwives in Australia.

Two more-detailed social science studies were identified, focusing on maternity care provision. The yet to be published work by Rolfe et al., in Tanzania uses multiple case studies to test a series of hypotheses about independent maternity homes run by ‘retired’ midwives. The
authors concluded that, in spite of their location in under-served rural and peri-urban areas, the bureaucratic, economic and cultural barriers to the expansion of this sector of provision have so far limited them from making significant contribution to improving coverage of skilled attendance at delivery. The authors flag up the importance of attention to local context in such analyses. De Vries’s sociological study of maternity care in the Netherlands is a sophisticated exploration of the infrastructural and cultural context that sustains independent midwifery practice and leads to a home birth rate of over 30% (De Vries, 2004).

The international empirical evidence indicates that that there are multiple factors involved in opportunities and choices for nurses and midwives when making the move into enterprise. It is not possible to be specific as to the extent that offering choice to users of health care was a motivating factor for nurse and midwife entrepreneurs.

4.4 NMHV entrepreneurship in the UK

In this section we focus on the results of our literature reviews and e-scoping of UK NMHV entrepreneurial activity. We offer three analytical cuts of these data. Firstly, we map and analyse some detail the types and extent of NMHV intra- and entrepreneurial activity (the remainder of Section 4.4). The second analysis attempts to better understand private/public configurations through the application of a provision/financing/decision-making framework (Section 4.5). Finally, in the third analysis we examine the aspirational claims made in the documents concerning self-employed and business NMHV entrepreneurial activity, and consider whether and where the enhancement of patient choice fits within these claims (Section 4.6).

There is no single organisational body or source of information on the extent of NMHVs behaving intraprenerially or entrepreneurially in the UK. We have therefore focused on those NMHVs working within the health care system or connected to health care and do not consider those who are professionally qualified but who are now working in different sectors. During the course of this scoping exercise the discussion of entrepreneurial activities and behaviours by nurses have become increasingly visible in the public domain. Examples include:

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11It is beyond the scope of this review to consider the impact of their NMHV background and training on entrepreneurs whose activities are outside the health and social care field. Nevertheless, there are notable examples such as Ann Gloag, a former Scottish nurse who achieved enormous international commercial success in the transport industry (current fortune estimated to be £385m [Times Rich List, 2006]). Less well documented are her philanthropic activities in the provision of health care internationally (including the Mercy Ship floating hospital ships) and education for health professionals, particularly nurses in Scotland (Marie Curie 2001) and the endowment of a chair in nursing.
Platform presentations on nurse entrepreneurs and enterprise in conference programmes aimed at nurses in primary care.

Platform presentations on nurse entrepreneurs included at conferences aimed at managers and clinicians addressing chronic conditions.

The Department of Health funded nurse entrepreneur education programme at the Skoll Centre for Social Entrepreneurship, Said Business School, Oxford University (Department of Health, 2005c).

4.4.1 The range of NMHV entrepreneurial activity in the UK

We have analysed the evidence for entrepreneurial behaviour by NMHVs and suggest a typology that distinguishes between those who are employees — the intrapreneurs (see Section 2) — and those who are employers or self-employed – the entrepreneurs. We have identified some distinct categories by activity within each of these groups, which are listed in full in Box 1. For each group we:

- analyse the extent of current activity, as reported in the documents reviewed and in the e-scoping and expert seminars
- summarise what is known about the contextual and individual drivers (the push and ‘pull’ factors including specific triggering events)
- identify barriers to expansion of activity
- raise questions for future investigation.

**Box 1 A typology of NMHV entrepreneurial activity**

- The NMHV entrepreneurial employees (intrapreneurs)
  - NMHV in quasi–autonomous public health roles
  - NMHV in clinical specialist roles
- Employers/self-employed providers of services with an indirect relationship to health care
  - Nurse consultancies
  - Infrastructure and workforce providers
  - Inventors/manufacturers
- Employers/self-employed providers of direct health care services
  - Mainstream health services delivered through the NHS
  - NMHV services offered directly to clients
  - Other health-related services provided by the NMHV directly to a client
  - Accommodation with nursing and health-related services provided by NMHV proprietors
4.4.2 The intrapreneurial NMHV employees

The boundaries between activity aimed at service improvement and the introduction of innovation, professional leadership and behaviour that might be described as specifically ‘intrapreneurial’ are hard to define. Innovation and change are a constant feature in most health care organisations. Innovations have been described as occurring along a continuum, ranging from incremental (i.e. related to service improvements, population change or patient empowerment issues) to revolutionary innovations (i.e. influenced by change in financing, technology or biotechnology [Asoh et al., 2005]). Descriptions of NHS innovations involving nurses and midwives and evaluations of small-scale innovations are legion. They feature in every edition of the nursing press, in Department of Health information and guidance documents aimed at nurses and in annual award competitions run and reported by journals such as Nursing Times and the Health Service Journal. Against this background, it is possible to identify two groups of NMHVs who might more closely fit the description of employees behaving in entrepreneurial ways to the benefit of the users and the organisation i.e. as intrapreneurs. These are:

- NMHVs in quasi-autonomous public health roles
- NMHVs in clinical specialist roles.

**NMHVs in quasi-autonomous public health roles**

Health visitors and those nurses educated in the UK public health tradition share an underlying philosophy for their roles that involves identifying unmet health (in the broadest sense) needs in the population and seeking ways in which they can be addressed. This philosophy is perhaps best encapsulated by the statements used to describe the principles of health visiting at an individual, group and population level (Twinn and Cowley, 1992) as being:

- The search for health needs
- The stimulation of awareness of health needs
- Influencing policies affecting health
- Facilitation of health-enhancing activities.

Thus the roles of NMHVs working in public health have tended to encourage autonomous and innovative behaviours. There have been more opportunities for intrapreneurial work for these nurses than for other types of nurses, particularly with increasing emphasis on cross-agency working and networking with the voluntary sector and local authority sectors. We identified more than 260 published examples spanning a wide spectrum of activity in this area (see Appendix 7, Table 7 for examples). At one end of this spectrum, the development of new services may only involve the re-organisation of the NMHVs time to provide their own services differently or more accessibly to a particular client group (e.g. Harrison and Berry, 2006). At the other
end of the spectrum, there are NMHV activities that are more overtly intrapreneurial, which include:

- Those who work using the principles of community development or community engagement in helping communities identify their own health issues and working with them to address them (e.g. Grant, 2005). There are examples where the nurses and health visitors not only work in these ways but also actively draw in additional funding from outside the health service. Examples include:
  - health visitors who led the development of a tenants association that subsequently gained £1.2 million in government urban renewal funds (Beacon Community Regeneration Partnership, undated)
  - health visitors who led a community health project based in a community flat on a deprived estate and won a financial award from the Queen’s Nursing Institute (Daniel, 1999).

- Those providing health care services in a manner that appears pioneering or ‘risky’ for the NHS. An example is the innovation of improving access to post-coital oral contraception in school settings, as instigated by school nurse Viv Crouch in response to the reduced local teenage pregnancy strategy (Crouch, 2002). This resulted in local and national outcry concerning the acceptability of this approach and led to questions in the Houses of Parliament (Tonge, 1999).

These kinds of activity pre-date the policy changes from the mid 1990s and have often been tied to improving access and addressing health inequalities (see, for example, Drennan, 1988). Many have been short-term projects limited either by the temporary nature of the funding or by reliance on a single innovative individual whose eventual departure leaves a gap that cannot be filled. The nature of the documentation of such projects often makes it difficult to discern their characteristics, such as:

- to what extent an NMHV could be considered as the prime agent in the activity
- to what extent it was a multi-professional initiative
- what the outcomes were
- how long the activity was sustained.

In accounts of such activities the drivers tend to be described in terms of ‘fulfilling one’s job role’ and ‘addressing inequalities in health’, often claiming legitimacy by citing from government policies on public health (Department of Health, 1999b). In the literature that we have reviewed, the key obstacles to innovation and intrapreneurial activity are reported to be limited finances affecting sustainability; difficulties surrounding decision-making and finding support between multiple agencies; and the controversy that some initiatives generate. We discuss these obstacles in more detail below after discussion of the second group of more entrepreneurial employee NMHVs.
**NMHV in clinical specialist roles**

NMHVs working as clinical specialists are a second group of employees that exhibit more entrepreneurial behaviours. Clinical nurse specialists are a group who focus on one condition, health problem or a specific population group. They are recognised as experts in their field and are often sought as advisors to others and are involved in service developments and innovations. However, it is difficult to separate instances of service improvement and direct substitution of single medical tasks from instances where NMHVs provide a full service more entrepreneurially, in which care is assessed, managed and evaluated by the nurse in partnership but without direct medical input. There is an extensive literature of UK nurse-led specialist services. For example, the Department of Health funded study Exploring New Roles in Nursing Practice (ENRiP) in the acute sector (Read et al., 2001) estimated approximately 3000 clinical nurse specialist roles involved nurse-led activity nationwide. The ENRiP case study work demonstrated great variety in the support and obstacles experienced by those in new clinical nurse specialist roles (Read et al., 2001).

‘Agency’ and ‘risk taking’ are often said to be defining characteristics of entrepreneurial activity. In Table 8 (Appendix 7), we provide examples of the specialist NMHV roles within public sector organisations that could be said to involve one or other or both of these characteristics. Examples include:

- a nurse-led service to manage problems of intractable constipation in children in Oxfordshire (Muir and Burnett, 1999)
- a nurse-led heart failure and cardiac rehabilitation clinic at Basildon Hospital, Essex (Ayers, 2005)
- nurse-led cystoscopy and a follow-up telephone counselling service for patients with prostate and bladder cancer at Grampian NHS Trust in Scotland (Hoban, 2006)
- community mental health nurses providing advice for people with anxiety, depression or life difficulties in southern England (Kendrick et al., 2005)
- consultant midwives working to reduce caesarean section rates by developing counselling services for women who request caesareans without medical indications (Dunkley-Bent, 2004).

Many of these accounts make it clear that the NMHVs’ drivers included the desire to create patient-focused care, to maximise the use of their expertise and to improve the types of service offered by the NHS. Supporting environmental factors that were exploited included medical consultant support and government policy priorities, such as reductions in junior doctor hours and waiting time targets.

**Intrapreneurial NMHV and health organisations**

Innovative and challenging ideas are not always welcome in large bureaucracies, and a small literature describes the problems
encountered by members of the NHS workforce in trying to gain organisational permission to behave in ways that are different and creative (see for example McMurray and Cheater, 2004).

Several contributors to the expert seminars also cited these difficulties as the impetus for their own departure into independent practice. Seminar participants wanted more autonomy over their work and reported the frustrations of what they perceived as inhibiting practices. For example, one participant said:

‘If I reflect that when I qualified as a health visitor in ‘73, we were told, “there’s your caseload, get on with it. Do with it what you wish”. Nobody checked up on us, so I did with it what I wished. And by the time it came to be constraining, I’d moved into education, and I was teaching my students to do with it what they wished! We were taught to be autonomous and to have a look and to make decisions. And I think, for me, that actually when the NHS started to shut down all that, I found that really hard. That wasn’t the way I functioned.’

However, there are also examples from the literature where local NHS organisational support has been explicit in creating posts for ‘leaders’ and ‘innovators’ with job descriptions that embody and enable these types of activity. These are usually created in recognition of the fact that conventional approaches to care and service delivery have failed some of the most vulnerable groups, for example:

- Outreach sexual health and contraception nurses with a remit to provide their services in ways and places acceptable to particular client groups, such as men who have sex with men, teenagers, sex workers (Knox, 2004).
- Consultant midwives within NHS trusts with responsibility for public health running community clinics focusing on domestic violence, the sequelae of rape and sexual assault, traumatic childbirth and mental ill health (Dunkley-Bent, 2004).
- Sure Start midwives working with poor communities and with specific client groups that can be difficult for maternity services to reach, such as pregnant women who are substance abusers (Hutchings and Henty, 2002; Khazaezadeh, 2005; Wilyman-Bugter, 2003).
- Community development health visitors (e.g. Swann and Brocklehurst, 2004)
- Specialist in complementary therapies using massage, reflexology and aromatherapy within the hospital setting
- Outreach mental health nurses working with young people with sexually harmful behaviours (National Institute for Mental Health in England, 2005).

It is not clear which factors make it easier for individuals and organisations to support such intrapreneurial activity or whether these are different from the known factors that support and sustain innovation in the NHS. It is possible to hypothesise that certain public
sector environments are more nurturing of intrapreneurial activity than others, for example where there is:

- Greater availability of local-level funds such as the single regeneration budgets (Department of Communities and Local Government, 2004).
- Public sector service policy, such as public health policy (Department of Health, 1999b) that explicitly describes NMHVs acting in this way.
- Central government funding for cross-agency initiatives such as Health Action Zones (Department of Health, 1997b), Sure Start (Department of Health, 1999b), Crime and Disorder Partnerships (Crime and Disorder Act, 1998).

**Research questions**

- To what extent is any intrapreneurial activity in the NHS the result of one person’s activity, drive or motivation?
- What are the key features of an NHS organisation that supports intrapreneurial activity by NMHVs?
- What factors external to an NHS organisation are likely to support or inhibit intrapreneurial activity by NMHVs?
- Is there any link between the types of education, background and/or the level of seniority that support intrapreneurial behaviour by NMHVs?
- To what extent does the relationship with doctors (and which types of relationships with which types of doctors) support or inhibit NMHV intrapreneurial behaviour?
- Do NMHV roles that have clearly defined focus and boundaries encourage intrapreneurial activity on behalf of their client groups?

Before leaving this section on intrapreneurial behaviour, it is worth noting that intrapreneurs often cross boundaries: working within the health care system while also working alongside but outside it. This appears to be a characteristic of some NMHVs who have been working on innovative/cutting edge/risky services within the NHS. These individuals have often actively publicised their work, with the result that their names are nationally associated with this activity. Many have subsequently left the NHS (sometimes to the associated public sector of health professional education) but they have continued the activity, or an aspect of it, outside the NHS. For example:

- Professor Elizabeth Anionwu established the first nurse-led sickle cell counselling service in the UK in the Brent Haematology Service. She raised public awareness of the deficiencies in the NHS response to black and ethnic minority health issues, promoting improved counselling and care services (Anionwu, 2005). She was a founding member of what later became the UK
Sickle Cell Society and has continued since the 1990s to be actively engaged in this area from the higher education sector (see for example Anionwu and Atkin, 2001).

- Ellie Lindsay, who as a district nurse established ‘leg clubs’ for older people to prevent ulcer re-occurrence and provide social interaction opportunities, then left the NHS for higher education and also set up a charity (the Lindsay Leg Club Foundation), which promotes the ‘leg club’ model in the UK and Australia (see http://www.legclub.org/index.shtml, and Pollard, 2004).

These examples illustrate the unpredictable career trajectories of intrepreneurial nurses, even when their focus is on responsiveness to patient need.

### 4.4.3 The NMHV entrepreneurs in the UK

As indicated earlier (Section 4.4), there is no single register, organisation or source of information revealing the types or extent of NMHV entrepreneurs as owners/employers/partners of enterprises in the UK. While the RCN has 201 members registered in the Nurse Entrepreneur Forum (Smith, 2006) this is only open to members of the RCN and thus gives only an indication of potential numbers. Membership of this forum is unlikely to include many midwives. At the time of our scoping exercise, there were 115 independent midwives registered with the Independent Midwives Association, and an indeterminate number of others who practise independently but who are not members.

In order to understand the extent and character of NMHVs’ activities in business, we have constructed a categorisation from the examples we have found, based on the types of products/services (see Box 1). We have done this because much of the literature provides few details that would allow categorisation in other ways, such as type of business (sole trader, partnership, limited company, co-operative) or commercial versus social entrepreneurship (see also Section 2). The lack of detail in the accounts means that we cannot always distinguish accurately the extent to which these services are bought or commissioned by the public or private sector or by individual patients/clients (see Section 4.4).

Within the employer/self-employed category, we distinguish between providers of services with an indirect relationship to healthcare and providers of direct healthcare services. This does not mean that individuals necessarily only operate within one category. It is noticeable that many of those operating as sole traders (self-
employed) who provide direct clinical care also offer nurse consultancy services.

In the following sections, we detail the extent and available evidence on the context, drivers and barriers and outcomes for each group. We indicate in each section the questions raised from the evidence and summarise these at the end.

4.4.4 Providers of services with an indirect relationship to health care

NMHV consultancies

These NMHVs use their expertise, knowledge and experience to provide consultancy to a wide range of public and private sector organisations. The types of expertise they offer in consultancy are:

- clinical leadership and advice on health care delivery
- service commissioning or clinical practice review or audit
- service or clinical practice project planning and implementation
- training programmes/workshops
- expert witness opinion in legal cases
- risk-management assessment and planning
- occupational health and safety advice
- individual coaching; motivational and personal development; career advice.

Table 9 (Appendix 7) provides a sample of these consultancies from published information. In total we have identified 40 nurses, 4 of whom were men. Many of these individuals reported that they were senior managers or clinical nurse specialists with many years’ experience in the NHS; others are nursing or midwifery academics. The reported drivers behind the move into individual consultancies included NHS management and education reforms and the downsizing of NHS organisations and associated schools of nursing. Other factors were the desire to be in control of one's own activities, to gain recognition for their work and to have more flexibility in working times. We found three examples of black and minority ethnic nurses offering NMHV consultancies; only one of these was a published account (Thompson, 2005). The literature on the entrepreneurial activities of black and minority groups in the UK and, in particular, women from Caribbean and Asian backgrounds (see Section 2), raises questions about the extent of entrepreneurial activity in NMHVs from minority ethnic backgrounds.

The individuals’ accounts report benefits, such as personal and professional satisfaction, time flexibility and being one’s own boss rather than being dictated to by an organisation. Reported problems include the slow start in getting the enterprise off the ground, concerns about peaks and troughs in the workload and uncertainty
about income levels. These factors mirror many of the drivers and barriers seen in the women entrepreneur literature, as identified in Section 2. It should be noted that some of this type of work, for example expert witness opinion, media and television advisors, is undertaken by people who are also working for the NHS at the same time. Indeed, some of the consultancy nurses reported working for the NHS as temporary staff when they did not have enough consultancy work.

**Research questions**

- What is the age profile of NMHV's moving into entrepreneurial activity and how many years of health care experience do they typically have?

- To what extent does the NHS lose NMHV's with significant clinical expertise to enterprise from areas experiencing organisational turbulence?

- To what extent do clinically and managerially experienced NMHV's develop portfolios of different types of work and income streams?

- How do the career trajectories of male and female NMHV entrepreneurs compare?

- To what extent are NMHV's from black and minority ethnic groups represented in the entrepreneurial categories and are their career and entrepreneurial trajectories similar to NMHV entrepreneurs from majority ethnicities?

An additional category of nurse consultancy was reported in the expert seminars, whereby a clinical nurse specialist acted as a private care commissioner on behalf of individual patients. This nurse worked with 14 children with acquired brain injury; her role was to use her technical knowledge to commission care for them from other experts, not to provide the care herself.

**The infrastructure and workforce providers**

We identified four nurse entrepreneurs running businesses that provided infrastructure services or staff to health care services (see Table 10, Appendix 7). There are likely to be further examples, but the cases we found have been particularly visible in the media and are repeatedly cited as examples of nurses working in business. This media focus has concerned:

- Their business success – Ann Rushworth founded the ScotNursing agency for temporary nursing staff in 1996; this now has an annual turnover of £10 million (www.scotnursing.com).

- Successfully identifying a market gap – Kate Bleasdale founded MediCentres, the first private GP walk-in services in railway stations, an idea later picked up in the NHS Plan (Department of Health, 2000).
Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

- Successful examples of private–public partnership or third-sector enterprise promulgated in health policy for England – Sarah Chilvers in partnership with Rory McCrea (a GP) established Chilvers McCrea Health Care Vision to provide corporate management services to general practice and latterly to provide the entire service under APMS contracts (Chatterjee, 2005; www.chilversmcrea.co.uk).

- Controversy – Kate Bleasdale won an out of court settlement said to be £2.2 million for alleged sex discrimination and unfair dismissal from the nurse returner recruitment company MATCH that she founded and led as chief executive (Vasagar, 2002).

The scoping exercise did not reveal accounts of failure or nascent NMHV entrepreneurs in this field. It did, however, reveal involvement in the wider business world not discussed in any other part of the scoping, for example companies being floated on the stock market, mergers with other companies, takeover bids and management buy-outs. Much of the literature about these entrepreneurial nurses comes from news reports and therefore there is little information about their motivation, drivers and barriers. Market opportunities are presented in various ways, for example:

- Offering the public a choice in provision – private GP walk-in centres at railway stations.

- Offering services that compete on the grounds of efficiency and effectiveness – provision of corporate infrastructure services to general practice; provision of temporary staff.

Kate Bleasdale left the NHS and set up her first company in her twenties and within 4 years of qualifying as a nurse (Wallis, 2003) – an unusual pattern compared to that portrayed in the literature on women entrepreneurs. Sarah Chilvers and Kate Bleasdale have reportedly been involved in more than one enterprise, suggesting the characteristics of ‘serial entrepreneurs’ are to be found among some of this group. Ann Rushforth, a former midwife, is reported to have started the ScotNursing agency from her spare room partly because it was impossible for her to find work that would fit in with her family of three children then aged under 4 years, and partly out of a desire to run her own business. It should be noted that there are also two examples of the companies that these nurses founded providing direct patient care – although they themselves did not. This illustrates the overlapping nature of some of these categories.

It is not clear whether these individuals are still registered to practise as NMHVs in the UK. In some instances, they are described as being a ‘former nurse’, however their nursing qualifications are often given with their names.

Research questions
Inventors/manufacturers

Inventors and manufacturers were the final group of NMHV entrepreneurially in indirect care. We identified six examples (listed in Table 11, Appendix 7) ranging from medical devices for use in patient care (e.g. an earwax softener applicator), to health promotion artefacts (e.g. a board game to raise sexual health issues with young people with learning difficulties) and aids for health professionals (e.g. miniature laminated aides memoires). The reported drivers came directly from the experience of providing services and a desire to improve patient care. Some of the accounts of these inventors and manufacturers are journalistic and, as such, financial start-up details, outcomes and aspects of intellectual property rights issues are not always clearly described. One of the inventors was also part of a family farming business (Porokhynya, 2005).

We have identified one further example where a health visitor working in higher education identified the need for a chair that allowed better positioning for breastfeeding in comfort. She took her idea to a design student, who developed the idea as doctoral work and subsequently took her work to an independent manufacturer. The chair is now in production and commercially available. The health visitor entrepreneurial activity from a practice-based need was instrumental but is not necessarily now visible (Jones et al., 2006).

Research questions

- To what extent do entrepreneurial NMHV have family or previous experience of the business world?
- To what extent does the NHS encourage and support inventions by NMHV and deal with issues such as intellectual property rights?
To what extent are NMHVs providing the creative ideas, identifying the market gaps and initiating entrepreneurial ways of addressing them but then leaving their innovations to others to develop and profit from?

We turn now to those NMHVs providing direct health care services either as self-employed individuals or as employers.

4.4.5 Providers of direct health care services

These can be categorized into four groups:

1. Mainstream NHS health services provided through direct contract with the NHS.
2. NMHV services provided directly to clients.
3. Other health services (e.g. complementary therapy and cosmetic services) provided by NMHV directly to clients.
4. Accommodation, with nursing and health-related services provided by NMHV proprietors.

Entrepreneurs in this group may be funded in a number of ways. Here we describe the scope of this category of activity, with illustrative examples from each subcategory.

**NMHV providers of ‘mainstream’ NHS health services**

This group is diverse with respect to trading status and contractual mechanisms with the NHS. The diversity has increased during the life of this scoping exercise and is set to increase further, as the government has announced support for the increased presence of ‘third-sector providers’ (Department of Health, 2006) in health care outside of hospitals in England (see Section 3).

The groups we have identified are:

- Nurses as partners in general practice businesses with national (GMS) or local (PMS) contracts with the NHS.
- Nurses as sole traders and partnerships in providing personal medical services (PMS) under the Primary Care Act 1996 regulations, i.e. services comparable to those specified in the GMS contract but contracted with the local Primary Care Organisation (PCO).
- Nurses providing PMS under APMS contracts, i.e. services comparable to those specified in the GMS contract with general practices, but contracted with the local PCO.
- Nurses as directors of not for profit companies providing community health services (not PMS) under APMS and specialist provider medical services (SPMS) regulations, contracted with the local PCO.
Independent midwifery practices sub-contracted from an acute health care trust, as in the Albany/King’s College Hospital Trust arrangement (see below).

An explanation of the various primary care contracting routes is outlined in Appendix 6; examples are given from the literature in Table 12 (Appendix 7).

Nurse partners in general practice and nurse-led PMS

Partnership for nurses in general practice businesses became a legal option for contracting within the NHS with the passing of the NHS (Primary Care) Act 1997. This act allowed a PCT to contract directly with an individual practice rather than through the national contract with individual general practitioners. The first nurse partner with a GP in a general practice business was announced in 1998 as part of the initial wave of 94 new PMS contract pilots. In 2006 it is reported that there is a network of up to 100 nurse partners and prospective nurse partners (Pearce, 2006). The increase is reported to have been promoted by the legislative changes to primary care contracting that took place in 2004 (Crumbie, 2006). The increased interest is illustrated by the production of guidance on how to be a nurse partner by a Department of Health funded organisation, the National Primary and Care Trust Development Programme (National Primary and Care Trust Development Programme, 2005), and by professional nursing organisations, such as the Queen’s Nursing Institute (Queen’s Nursing Institute, 2005). There are three different levels of nurse partnership with different levels of financial investment in and return from the practice. As pointed out in the National Primary and Care Trust Development Programme paper (2005), partnership in a general practice is not a risky financial business, as illustrated by recent media accounts of GP incomes in excess of £100,000 (see for example Hawkes and Charter, 2006). The contract with the NHS guarantees income without risk of financial loss (National Primary and Care Trust Development Programme, 2005). While nurse–GP partnerships are growing in number, they make up a small proportion of the 10,683 UK general practices (Royal College of General Practitioners, 2005) and practice nurse workforce (see Section 2).

We found published accounts of five nurse partners with GPs, three established in the first wave of PMS pilots and two since (see Table 12, Appendix 7). All of the accounts describe a long history of working in that general practice and development of a role and services. This implies that there are certain contextual and relationship pre-requisites for NMHVIs in order for them to be invited to become business partners. All accounts place emphasis on the positive contributions of the nurses to holistic patient care, a nurse-led approach or culture. The only barrier reported by one nurse partner was the fact that the RCN does not indemnify a business partnership (Crumbie, 2006). There are no accounts of the impact, sustainability or effects over time of nurse–GP partnerships. The advent of nurse
partners in general practice indicates that nurses are becoming business women/men rather than necessarily becoming entrepreneurial risk-takers with innovative ideas for patient care or choice.

Of the 94 first-wave PMS pilots announced in 1998, 2 were led by independent nurses who gained contracts with PCTs and employed salaried general practitioners. A further 7 were involved in nurse-provided PMS pilots, although it was usually the PCT that held the contract. This first wave of nurses were described repeatedly in the media as ‘pioneers’, ‘ground breaking’ and ‘in the vanguard’. All but one of these nurses were female. Accounts were given by the nurses themselves, by journalists, by an academic reporting on focus groups held with all of these nurses 12 months after starting (Lewis, 2001) and by one evaluation of 28 patients’ perceptions in one of these practices (Chapple, 2000). Drivers of the entrepreneurial act were described in terms of the opportunity the legislation gave the individuals and nurses as a profession. Some of the drivers were described in terms of opportunities to address the health care needs of vulnerable patients and to improve health care in deprived areas. Support was described as coming from other nurses attempting to get nurse-led contracts and from the active involvement of senior civil servants and leading figures in the nursing world. The barriers were described as the isolation, lack of a safety net and negative attitudes from some doctors, managers and nurses. For example, one nurse, who attended an expert seminar, described the isolation they felt because they were ‘treading ground no one had trodden before’ and stating that ‘every GP wanted me dead, but nurses wanted me more!’. Another barrier was the lack of parity between doctors and nurses in health care administration, for example signing death and sickness certificates and prescribing powers. It was also noted that the Act did not allow health authorities to allocate grants for the improvement of premises to nurses, as they did to doctors. One of these nurses reported patients’ concerns about whether this type of practice meant there was a two-tier system of health care (Chapple, 2000), while another cited the increased level of patient registration as evidence of success (Baraniak, 2001). Interestingly, one of the nurse-led PMS pilots established an innovative governing body, modelled on that of a school board of governors, which involved patients and city councillors to help direct the work of the nurse-led PMS (Chapple, 2000). There are no published patient or practice outcomes reported in these accounts, which instead focus on the set-up process. Informants from the expert seminars suggested that practice-level data exist within PCOs demonstrating improvements in public health and chronic disease management indicators in these practices compared to prior population figures. However, it is difficult to say how far this is an example of new workers annexing an old model of care or a radical change in primary care provision led by entrepreneurial NMHV.
There is no published information to show how many of these pioneering nurses remain leading PMS. One left after 2 years and is quoted as questioning the premise that the most vulnerable and needy in the community were best served by nurse-led PMS when the reality was that the best services relied on a partnership between GPs and nurses (Moore, 2002).

The government established PMS as a permanent alternative form of contracting to the GMS contract and, by 2004, 37% of all GPs (n=11,547) were using this form of contracting rather than the GMS contract (Royal College of General Practitioners, 2005). There is no published information as to the extent to which nurses have continued to take up the option of nurse-led PMS since the first wave.

We have found only one account published after the first wave of PMS pilots that describes a partnership between the practice manager and the practice nurse (also a health visitor) to gain a PMS contract with the PCO, as they were taking over their employer’s practice on his retirement. Interestingly, this is one of the few accounts that describes the finance involved, which involved raising a £250,000 bank loan to buy a practice from a GP, and also reports the nurse describing herself as ‘a bit of an entrepreneur and a risk taker’ (Houghton, 2002). It is noteworthy that a nurse setting up in practice is perceived as entrepreneurial, while a doctor setting up a practice would be seen only as a business person. This account states that the remaining barriers are the differences in prescribing authority between doctors and nurses (although the 2006 legislative changes on non-medical prescribing alters this in England) and the difficulties in attracting GPs to work in salaried positions with a non-GP-led practice. This may indicate a more widespread resistance to nurses taking the employer role or holding these forms of contracts.

APMS and SPMS contracts with the NHS

The negotiation of the new GMS contract in 2004 was instrumental in the government creating a new category of primary care contract, known as APMS (alternative provider medical service). This opened the way for a range of public, private and not for profit organisations to tender to the PCT to provide specific PMS or parts of them, for example out of hours services (Hutton, 2004; Maynard, 2004). During the lifetime of this scoping exercise, a third type of contract has been developed for a wider range of primary care services outside of general practice: SPMS (specialist provider medical services) (Department of Health, 2005c).

In July 2005, the Department of Health announced a national procurement pilot to demonstrate how different routes of contracting with different types of providers could address problems in areas where it was hard to recruit GPs (NHS Procurement and Supply Agency, 2005) examine. Increasingly over the last few months guidance has been issued on the tendering process and the variety of
organisations that could be third sector providers for care outside of hospital (Department of Health, 2006). The development of this new form of third-sector provider is not without controversy (see for example BMA, 2006, Harding, 2006). The types of organisations that have been tendering include existing GP partnerships (Arie, 2006), small and large commercial companies (Anon, 2005a; Snow, 2006) and not for profit (and mutual) organisations (Harding, 2006; Lewis et al., 2006).

We have identified one company that has a nurse as one of the directors, and which has gained APMS contracts from PCTs to provide PMS (Chatterjee, 2005; O'Dowd, 2006). In addition, we have identified a nurse partnership that successfully tendered for an APMS contract using finance from a social enterprise company (Wild, 2005). One nurse and therapist manager-led bid to provide community nursing and therapy services as a standalone social enterprise under a SPMS contract has been successful (Carvel, 2006; Nolan, 2006; Pritchard, 2005). These enterprises are very recent and, in the positive and multiple media reporting, it is difficult to understand their triggers, processes, impact or sustainability. It is noteworthy, however, that other nurse-led partnership bids for APMS contracts (Anon, 2005b) have not been successful against a larger company, UnitedHealthcare.

**Midwifery practice contracting**

Midwifery services in the UK currently ‘belong’ administratively in the acute rather than the primary care sector in financing and administrative terms. The Albany Practice contract with King’s College Hospital Acute Trust in London is currently the only example of an independent midwifery practice with an NHS sub-contract to provide services to a specific population. Based in southeast London, this self-managed, self-employed group of midwives has offered continuity of care with a known midwife since 1997, with the aim of targeting certain groups of local women and improving equity of access in a deprived area of London. The group was previously run as a pilot funded by the NHS Executive, which helped secure the subsequent contract with the hospital trust (Allen et al., 1997). An evaluation of this midwifery practice showed that high rates of breast-feeding were achieved in a population that might otherwise be expected to have a very low take-up of breast-feeding (Sandall et al., 2001). In addition, high rates of home birth were achieved. The Independent Midwives’ Association has submitted a proposal for an NHS Community Midwifery Model to the Department of Health in which a set fee per woman would be paid by the NHS to independent midwives who would continue to enjoy ‘different ways of working’ (Midwives Information and Resource Service, 2004). The proposed model would build in full access to NHS facilities and so resolve the difficulties that have been experienced by independent midwives in obtaining NHS honorary contracts and providing vicarious liability cover.
The extent to which ‘third-sector providers’ or ‘outsourcing’ becomes established in the NHS and whether it represents a more significant shift in how primary care services are provided compared with the growth in NMHV entrepreneurial roles remain to be seen.

**Research questions**

- What types of local and national level support, by which types of stakeholders, enable NMHVs to compete for contracts for mainstream NHS services?

- Are multidisciplinary tenders for APMS and SPMS contracts likely to be more successful than NMHV-only tenders?

- Are the tenders offered by nurse-led organisations for APMS and SPMS contracts different in any respect to those offered by other groups?

**NMHV services provided directly to the client**

The second category of NMHVs providing direct patient care that we identified were those whose NMHV services were provided directly to the patient/client and which were paid for by the patient (see also Section 4.4.1). Our scoping identified 11 nurse examples, 5 of which were from the grey literature (see Table 13, Appendix 7). The consultation and care services provided concerned continence, stoma care, rheumatology, ear care, maternity care and general health assessment. This group overlapped with the NMHV consultancies in Section 4.4.4. We also identified one example where the service (women’s health screening) was bought by companies who offered it to their employees.

A reported driver in one instance was early retirement from the NHS while two others described the opportunity to use their clinical expertise more flexibly in a way that gave them professional satisfaction. Reported barriers included the daunting prospect of being self-employed, the erratic nature of referrals and clients, and the costs of personal indemnity insurance.

‘Private’ or ‘independent’ midwifery practice, as it is usually termed, has a very long history in the UK, and prior to the 1936 Midwives Act which brought in a salaried midwifery system, it was the norm (Hunter, 1998). After the creation of the NHS in 1948, there was a steady decline in independent midwifery practice but it re-emerged in the 1970s with a strong ideological commitment to the pursuit of less medicalised models of care than those encountered in NHS services. The number of independent midwives has remained small (currently a little over a hundred) and they are mainly confined to urban areas. However, independent midwives have remained vocal advocates for ‘real’ midwifery, for physiological childbirth and for models of ‘woman-centred care’ that attempt to enact power sharing and empowerment of clients. The use of the term ‘independent’ rather than ‘private’ or
'entrepreneurial' in the literature when describing this group is not accidental. As Hunter (1998) says: 'it is the very independence of independent midwives that is so important. They do not need to convince the sceptics, negotiate with the managers or challenge the prejudices of co-professionals – they just go ahead and practice'. Drivers for practising independently include (Jackson, 1998):

- providing choice to women of where and how to give birth
- developing meaningful relationships with women
- gaining greater autonomy over one’s work
- achieving greater work/life balance
- frustrations with practising midwifery in the NHS
- disagreement with specific practices, such as continuous electronic monitoring during labour.

Independent midwives in the UK have faced great barriers in obtaining professional indemnity insurance, as the Royal College of Midwives withdrew cover for this activity because of rising costs, and they often have difficulty negotiating honorary NHS contracts from health authorities (Dimond, 2004; Kacary, 2005). Other reported barriers include problems with home–hospital interfaces and uncertainty about generating clients (Howes, 2005; Coyle 1999).

**Research question**
- To what extent do NMHV services directly paid for by the client offer something that is not available or not provided in an acceptable manner in the NHS?

**Other health-related services provided by NMHV directly to a client**

This category includes complementary and beauty therapies that are not usually commissioned by the NHS (although there is a great deal of variety in relation to complementary therapies).

There is no up to date literature detailing the extent of NMHVs provision of complementary therapy services paid for directly by clients outside the NHS. Andrews surveyed nearly 2000 complementary therapists across the UK and of the 426 who replied, 63 were also registered nurses and/or midwives (Andrews, 2003). The majority were female, practised as sole traders and for 57% their complementary therapy work was the sole source of income. The therapies they practised included homeopathy, reflexology, acupuncture, massage, reiki, hypnotherapy and dowsing. While some reported negative experiences in the NHS as drivers of their move out, others described the positive pull of wishing to work in the complementary therapy field or wanting more flexibility in their working lives for domestic responsibilities. Negative aspects of self-employment were reported to be similar to those described in the enterprise literature (see Section 2), including unpredictability of
income, lack of financial security and isolation. Interestingly, 70% reported that they would prefer to practise as employees of the NHS.

We identified no further published accounts of NMHVAs as complementary therapists, although a number of complementary therapy websites were identified that referred to therapists as former NMHVs. These websites helped us to identify the wide variety of ways in which these former NMHVs were operating. We found websites for:

- groups of therapists
- therapy centres in which the former NMHV was renting consulting rooms to other therapists
- former nurses and health visitors establishing UK branches of the Massage in Schools Association
- commercial status unspecified
- providing instructors to schools and early years environments
- a charity to fund the provision of a specific complementary therapy to children (www.abreathforlife.org).

Another group of nurses in the cosmetic procedures or beauty therapy field, was identified that was selling services directly to the public. A news item reported that over 300 belonged to the RCN ‘aesthetic nurse forum’ (Strachan-Bennett, 2005). The procedures provided included laser treatments and injecting botulism and collagen fillers. Recent Department of Health guidance has tightened up the regulation of providers of cosmetic procedures through the Health Care Commission. We were unable to identify further literature on this group of nurses.

**Accommodation with nursing and other health-related services provided by nurse proprietors**

In this category we identified nurse proprietors of care homes, although we were not able to identify the extent or the involvement in particular types of care homes.

In a survey and interview study of 100 private residential home owners in Devon, Andrews and Kendall (2000) identified that 30 (28%) were former registered nurses. It is difficult to know whether this is generalisable beyond Devon. Andrews and Kendall (2000) reported that the former nurse proprietors most commonly started their business to gain greater control of their own career and to own a business. No negative push factors from the NHS were reported and the authors speculated that any money-orientated motivation was not reported to the researchers. They noted that the former nurse proprietors had little business management training. This became particularly evident with the adverse market conditions that occurred during the mid 1990s, which made small residential home ownership more financially pressured and insecure.
We found only one other example of a nurse proprietor of a care home, which was for people with learning disabilities (Taylor, 2005). The decrease in the number of independent care homes as a result of new regulations and new market economies (Netten et al., 2005) might suggest that there are likely to be fewer nurse proprietors than in previous decades.

In the preceding sections we have explored the diversity of NMHV entrepreneurial activity in the UK. We have highlighted the NMHV contributions both in the fields of indirect health care-related activity and in direct health care provision. Through the examples of the latter, the variety and importance of financing arrangements becomes apparent. In the next section, therefore, we offer a slightly different analysis of that data, based on a model from the health economics literature. The aim of this analysis was to help us focus on the ways in which the intra- and entrepreneurial activities devoted to the direct provision of health care are currently configured across the so-called private–public divide.

4.5 Public and private configurations of health care and UK NMHV entrepreneurial activity to date

This section presents a preliminary analysis of the documents specifically concerned with NMHV entrepreneurial activity in provision of direct health care, using a theoretical framework that moves beyond a simple discrimination between ‘public’ and ‘private’ health care to separate the dimensions of provision, financing and decision-making. This in turn assists in identifying the relationship between specific configurations and a ‘patient choice’ agenda.

Figure 2 Classification of entrepreneurial activity in direct health care
provision by decision-making, financing and provision.

In this ‘ideal type’ model constructed by Burchardt et al. (1999), the supply side of health care is divided into ‘public’ (government) provision and ‘private’ (non-government) provision, and the demand side is split into ‘decision-making’ and ‘finance’. Finance refers to the source of the resources, for example, state or local authority budgets, or out of pocket payments. Decision-making, depicted in the segments in the inner circle of the figure (Segments 1–4), refers to whether the decision on what provider/service/goods to use is taken by a public body, by agents acting on behalf of consumers, or (as in Segments 5–8) by the ‘consumer’ or patient themselves (Keen et al., 2001).

So where does current NMHV entrepreneurial activity in service delivery sit with regards to the possible public and private provision, financing, and decision-making combinations? We examined the documents that related to NMHV entrepreneurial activity and the selected examples concerning intrapreneurial activity for the direct provision of health care services and where they fitted within the Burchardt et al. classification scheme. The findings are given in Table 4.

<table>
<thead>
<tr>
<th>Finance/decision/provision combination</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public decision</strong></td>
<td></td>
</tr>
<tr>
<td>Segment 1 (public provision/public finance/public decision)</td>
<td>36</td>
</tr>
<tr>
<td>Segment 4 (private provision/public finance/public decision)</td>
<td>31</td>
</tr>
<tr>
<td><strong>Private decision</strong></td>
<td></td>
</tr>
<tr>
<td>Segment 5 (private provision/private finance/private decision)</td>
<td>24</td>
</tr>
<tr>
<td>Segment 7 (public provision/public finance/private decision)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Insufficient information</strong></td>
<td>34</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>126</td>
</tr>
</tbody>
</table>

This allocation of information from a range of types of documents about entrepreneurial activity to segments is inevitably a somewhat crude exercise. One cannot necessarily assume that the documentation proportionately reflects the real-world activity and there was insufficient information in many of the documents to be able to assign them to a particular segment. Nonetheless, some tentative conclusions can be drawn.
Documented midwifery entrepreneurial activity, for example, features largely in three of these segments (1, 4 and 5). Those falling into Segment 1 (public provision, public finance and public decision-making) are the intrapreneurial midwives working within government provisions, such as the NHS and Sure Start. The entrepreneurs – independent midwives – are typically located in Segment 5 because they are primarily self-employed private providers of maternity services, privately financed by individual consumers who choose to opt for their care. This is an area in which patient choice, at the level of the individual who consumes this care, clearly appears to be enabled by the entrepreneurial activity (a question that this review was asked to consider). However, although a few practices operate sliding fee scales according to the client’s ability to pay, the charging of fees to the user does have implications for access to, and equity in, the choice of provider and care model. One well-documented self-employed midwifery practice in London – the Albany – demonstrates a different, Segment 4, category of entrepreneurial activity. In this model, there is private provision of care but the financing comes from the public sector in the form of a sub-contract from King’s College Hospital Acute Trust, which also chooses the care on behalf of the consumer. Advocates argue that this contractual model enables the best of the independent sector (high emphasis on ‘woman-centred’ care, continuity of carer, home birth and midwife satisfaction), while opening access to all, regardless of income. The Independent Midwives Association has proposed an NHS Community Midwifery Model along these lines, which would enable independent as well as NHS-employed midwives to use NHS facilities and to provide continuity of carer for all women (www.independentmidwives.org.uk). It argues that this model would sit alongside, rather than replacing existing models, thereby ‘increasing choice for women’ and helping to meet the aims of the National Service Framework for Children, Young People and Maternity Services: Maternity Services (Department of Health, 2004d) in which choice is also a central theme.

It appears that there is the potential for entrepreneurial activity to also fit within Segment 7, although this is poorly documented and we found only one example (Milan, 2005). Activity within this segment could be represented by an independent midwife who needs to take a mother into a public sector hospital either as an emergency or because the mother wants a hospital birth. To facilitate this activity, the independent midwife may have an honorary contract status with the NHS hospital. There is, however, no guarantee that such contracts will be issued (Hobbs, 1997).

Documented clinical nurse specialist entrepreneurial behaviour and NMHVs offering complementary therapies fall into Segments 1 and 5. Those falling into Segment 1 (public provision, public finance and public decision-making) are the intrapreneural nurses and health visitors working within government provisions such as the NHS and Sure Start. The entrepreneurs –privately practising specialist nurses or
NMHV complementary therapists – are located in Segment 5 because they are primarily self-employed private providers of services, privately financed by individual consumers who have chosen to opt for their care. Patient choice, at the level of the individual who consumes this care, might be enabled by the entrepreneurial activity in this area. However, as for midwifery, there is no evidence as to who purchases specialist nursing or NMHV complementary therapist service or why they decide to purchase this care.

In the UK there are already a number of different combinations of public and private financing, decision-making, and provision of health care (Burchardt et al., 1999; Keen et al., 2001) in existence. Nurse entrepreneurs providing accommodation with nursing or other health care services are private provision purchased with public or private finance, through both individual and public decision-making. The documentation identified in this scoping exercise on NMHV enterprise in this arena did not give sufficient information to allow analysis of which configurations prevailed or their contribution to patient choice.

General practice services have always been independent businesses contracted to the NHS by a public body decision, although the decision to use a particular service is within the domain of the individual. The small number of nurses becoming partners in general practice or holding PMS contracts (see Section 4.4.5) fall within Segment 4, as reflected in the analysis in Table 4. Similarly the small, but well-documented, number of nurses involved in new forms of business arrangements, which are tendering (as documented in Section 4.4.5) for APMS and SPMS contracts for the provision of PMS and community nursing and therapy services, would fall within Segment 4 of the Burchardt model.

The English policy commitment to develop a supply-side market of providers of primary care services (Department of Health, 2006) would suggest that the increased level of provision will sit in Segment 4 (privately provided) rather than in its current position in Segment 1 (publicly provided). However, the extent to which NMHVVs lead the development of enterprises and successfully tender for contracts in this market remains to be seen. Commentators offer scenarios of provider cartels in which practices are bought up by a single corporate entity or of local markets that are dominated by single GP-led companies (Smith et al., 2005), neither of which are likely to see solely NMHV-led enterprises flourish. Sketchy though the literature is for nurse enterprise activity in primary care contracts, our analysis suggests that it is likely to be a minority activity. In Section 4.4.5 we queried which environmental conditions are more likely to see successful nurse enterprise in this market and noted that early indicators point to less than supportive environments in some areas.

In Burchardt et al.’s analytical model, patient choice sits in the ‘outer circle’ of private decision-making; however, the concept of patient choice is far from straightforward. As highlighted in a previous review
commissioned by the NHS SDO programme, as well as by the participants in our own expert seminars, patient choice can be a slippery and contested term (Fotaki et al., 2005).

One way to approach this is to examine how the entrepreneurs themselves and those who write about them see their role in relation to any facilitating of patient choice, and it is to this analysis that we turn in the section that follows.

### 4.6 Aspirational claims made in NMHV entrepreneurship documents

In our third analytical cut of this literature, we have endeavoured to investigate where an aim of improving patient choice might sit within the range of objectives of entrepreneurial activity in these occupational groups. We have thus examined ‘aspirational claims’ – the statements that are made in the documents concerning what the NMHV entrepreneurial activity is expected, or intended, to achieve.

As we have already indicated, there is as yet little detailed research on nursing entrepreneurship in the health care area. There has, however, been some recent research drawing upon economics, social policy and social psychology in an effort to understand independent provider motivations within the social care area (Kendall et al., 2002; Knapp et al., 2001; Wistow et al., 1996) where the third sector and the private sector are majority care providers. In order to construct a framework for categorising the claims in the NMHV entrepreneurship literature we drew upon this work, specifically upon the range of motivations expressed by the owners of domiciliary care homes for the elderly, documented by Kendall et al. (1992). Through an iterative process the elements of the framework were tested against the documents and further refined.

The framework consists of four main ‘ideal types’ of aspirational claim:

- **Professional** aspirational claims are those stating that the entrepreneurial activity will allow development of, or greater use of, skills and expertise (to achieve further professional accomplishment, greater creative achievement, etc.).

- **Financial** aspirational claims concern how the activity will enable the generation of a satisfactory level of personal income and/or profit maximisation.

- **Mercantile** aspirational claims concern the entrepreneurial activity’s capacity to satisfy the entrepreneur’s aspirations for independence and autonomy. ‘Merchants’ in this sense are those service providers who are motivated by the possibility of exerting control over their own affairs, and who value the sense of independence and autonomy that comes from running a small business.
• Empathetic aspirational claims state that the activity meets the needs of a user group. For the purposes for this analysis we have subdivided this classification into three:
   – claims of improving patient choice
   – claims of improving equity and/or access to a service
   – other empathetic aspirational claims about user centredness/duty/responsibility (for example, in midwifery documents claims for ‘woman-centred care’ and for ‘building personalised relations with women’).

The purpose of this level of analysis is not to make any judgement about the validity of a ‘claim’ but in the first instance we are aiming to document and categorise what is being said about NMHV entrepreneurial activity.

The findings presented in Table 5 are derived from a total of 104 documents relating to NMHV entrepreneurship in the employer and self-employed categories\(^\text{13}\). Almost half of the documents (n=51) in Table 5 come from the primary care literature and half concern midwifery activity (n=53). Just as the motivations of many entrepreneurs in health care are multiple, so there are also multiple claims made for particular activities in some of the accounts.

| Table 5  Aspirational claims for NMHV entrepreneurial activity |
|---------------------------------------------|------------------|---------------------|
| Aspirational claims                      | No. of documents | Proportion of all claims made |
| Professional                              | 38               | 24%                 |
| Financial                                 | 10               | 6%                  |
| Mercantile                                | 51               | 32%                 |
| Empathetic: Improving patient choice      | 32               | 20%                 |
| Empathetic: Improving equity/access       | 5                | 3%                  |
| Empathetic: Other                         | 22               | 14%                 |
| No claim made                             | 24               | 15%                 |

These figures must be interpreted with caution for a number of reasons. Firstly, the documentation, as described in the methods section, varies considerably in quality and detail. Secondly, the literature we identified in a broad and rapid scoping exercise may reasonably reflect what has been written about NMHV entrepreneurial activity in the UK in the last decade, but it does not necessarily reflect

\(^{13}\) The ‘fuzzy’ boundaries of ‘intrapreneurship’ mean that material on this activity was drawn on only for illustrative examples and it was not included within the NMHV entrepreneurship documentation ‘core’ (see Section 1 for search criteria). Relevant additional information on this area is provided in illustrative footnotes and not in the data presented in Table 5.
actual entrepreneurial activity proportionately. Some areas may be over-documented and other areas may go largely undocumented (documentation of entrepreneurial nursing activity within the acute care sector, for example, is very sparse). Thirdly, there is the issue of interpretation. It seems likely that the expression of some aspirational claims – for example, those expressing altruism – may be felt to be more in keeping with the public image of the health professions than others (e.g. those expressing financial aims; see Section 5).

Despite all these caveats, a relatively crude analysis of this kind does render some interesting pointers to inform a future research agenda.

‘Mercantile’ aspirational claims were the most commonly expressed in this core literature on entrepreneurial NMHVs, and these featured in over 45% of the primary health care related documents. The entrepreneurial health worker’s desire to be autonomous, to organise their own work and to be responsible to themselves is a thread that runs through much of the documentation. ‘Professional’ aspirational claims accounted for about a quarter of claims. For example, documents claimed that the entrepreneurial activity allowed greater use of the nurse or health visitor’s skills, to develop new expertise or allowed the midwife to practise ‘true midwifery’. Participants involved in the expert seminars made both mercantile and professional claims for their entrepreneurial activities. For example, one participant described how the desire for job satisfaction was a push factor in them moving out of the NHS to start working independently.

‘And I think, when I first came, started working independently, it was because I wanted job satisfaction. I was so fed up with doing the job, where I knew I had knowledge and skills that nobody was using, I wanted to be able to use that and be satisfied in what I did.’

‘Financial’ aspirational claims were the least commonly expressed, featuring in only one midwifery and nine nursing and health visiting related documents.

About one-fifth of the documents contained aspirational claims for the entrepreneurial activity that related to improving patient choice in some way. Notably, this claim was a particularly strong theme in the midwifery literature, where it featured in just over half of documents. This may reflect the maternity field’s longer history of pressure from both user and professional groups for increased user choice of care model and place of birth. By 1993, ‘choice’ was set out as a key aspirational theme at the level of government policy with the Changing Childbirth report (Department of Health, 1993). That this claim was also made in the entrepreneurship literature highlights the extent to which the move of a small, but vocal and determined, section of midwives into independent sector activity was an explicit act of resistance to the ‘predominant ideology of medicalised childbirth’ (Hunter, 1998). Entrepreneurial midwifery makes claims about
improving choice for mothers in any or several of the following ways (Hobbs, 2001):

- choice of caregiver
- choice of type of care model and philosophy of care
- choice of location of care, particularly expanding choice to include home birth.

Few documents outside of the midwifery literature made the claim that the entrepreneurial activity they described was enabling patient/user choice. However, most participants in the expert seminars did feel that their own activity extended choice for patients – whether by offering specialist nursing services, complementary therapies or psychotherapy, or through service redesign (for example nurse-led medical services). Some providers of indirect services – typically those offering training in new skills areas – also felt that ultimately they, too, were contributing to increased patient choice.

In the documents concerning entrepreneurial services providing home birth care we found an intersection between claims for improving patient choice and specific claims about improving access to underserved groups. However, aspirational claims around improving equity or access to direct care provision do not otherwise seem to have been commonly made for NMHV entrepreneurial activities in the UK to date. In contrast, improving access to services and addressing inequalities would seem to have been the dominant features of the claims made in reports of activities undertaken by intrapreneurial NMHVs working inside the NHS.

4.6.1 Aspirational claims and the evaluation of outcomes

The scoping exercise suggests that very little is known about the impact of existing NMHV entrepreneurial activity. Table 6 indicates how few of the aspirational claims made in the documents were then measured for impact: 5 documents in the core 104 documents

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14 The elasticity of the notion of ‘enabling patient choice’ was highlighted in the expert seminars. Some participants, for example, felt that a midwifery group practice can be said to ‘offer choice’ if it encourages women to breast-feed where they would not perhaps otherwise. ‘Choice’ could also mean ‘allowing’ the opting out of care – not going to a GP, not having a cervical smear or not welcoming a health visitor into one’s house. ‘Patient choice’ could explicitly mean the creation of services that are more responsive to patients. For example, a GP practice in Leicester with opening hours to fit in with shift patterns at a local car plant – ‘it was purely respect for the patient base …. Nobody’s ever made a fuss about it and it was a remarkable piece of just being responsive’.

15 Some 20 of the 25 sample documents about intrapreneurial activity in primary care, for example, stated that they aspired to improved equity or access to care.

16 We found considerably more attempts at evaluation of aspirational claims in the intrapreneurial NMHV literature. For midwifery activity, for example, clinical outcomes measured including
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concerning entrepreneurial activity reported some sort of evaluation of activity in relation to the aspirational claims made for it (Milan, 2005; Walmsley, 1998; Chapple, 2000; Naish, undated).

Table 6 Frequency of the evaluation of claims

<table>
<thead>
<tr>
<th>Aspirational claim</th>
<th>No. making claim</th>
<th>No. measuring outcome in relation to claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>38</td>
<td>0</td>
</tr>
<tr>
<td>Financial</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Mercantile</td>
<td>51</td>
<td>0</td>
</tr>
<tr>
<td>Empathetic: Improving patient choice</td>
<td>32</td>
<td>3</td>
</tr>
<tr>
<td>Empathetic: Improving equity/access</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Empathetic: Other</td>
<td>22</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>158</td>
<td>5</td>
</tr>
</tbody>
</table>

Of those studies of NMHV entrepreneurship that did attempt to measure the actual enactment of the claims, one reported on the financial outcomes. This account reported company turnover, mapped on to a profit maximisation claim. The case study (Naish, undated) of Ann Rushforth, founder of ScotNursing, a nursing agency providing staff and training, reported an annual turnover of £10 million for the company in 2006.

Three studies made limited evaluations of the impact of the entrepreneurial activity on patient choice. Chapple (2000) evaluated patients’ perceptions of two nurse-led pilot schemes that had been running for 2 years. Through qualitative interviews with 28 patients, the author found that patients perceived nurses to be as knowledgeable as doctors and patients ‘felt they had real choice over who they consulted with’. Walmsley (1998) reported on care provided by an independent midwifery centre, the Wessex Maternity Centre, and assessed the choice given to women about the place of birth, with data from routine audits on rates of pain relief, transfers to hospital intervention rates (spontaneous labour, transfer to hospital; home birth, caesarean section) and breast-feeding rates (Rosser 2003; Milan 2004; Benjamin et al., 2001; Davies 1996). Women’s views on choice and control and of themselves after birth are reported (Rosser, 2003; Davies, 1996; Walsh 1999; Allen et al., 1997; Milan 2004). Documents report evaluations of the relationship between the midwife and the mother (Benjamin et al., 2001; Walsh, 1999), and stress and burn-out in staff (Sandall 1997) and midwives’ and mothers’ views of working in midwifery group practice development projects (Allen et al., 1997).
and water births. Milan (2005) similarly analysed 717 women’s records to compare the care provided by independent midwives belonging to the Independent Midwives Association to other published studies of caseload midwifery practice. A very small study provides qualitative data on ‘support and depth of trust’ in the relationship between midwives and women.

The almost complete lack of good process and outcome evaluations and the lack of answers to the question of ‘what works for whom, in what circumstances’ (Pawson and Tilley, 1997) is a substantial deficit in the existing literature on NMHV entrepreneurial activity in the UK. This deficit came as no surprise to the expert seminar participants. In the seminars, participants questioned whether outcome measures are ‘really relevant’ in a market system, ‘as if you have got something to offer in the way of a service/product/care, then as an entrepreneur you will survive’. However, a few participants were enthusiastic about outcome measurement as a marketing tool, even though there is a risk that results of such an audit may not show entrepreneurial activity to be working well.

4.7 Conclusion

We have mapped intra- and entrepreneurial activity of NMHVs in the UK and used this to create a typology, which needs further refinement through empirical investigation. The categorisations – by type of service, by configurations of public and private provision, financing and decision-making, and by aspirational claims made for the entrepreneurial activity – each offer complementary conceptual maps for understanding the very diverse range of intrapreneurial and entrepreneurial activities undertaken by NMHVs. They also facilitate more detailed examination of some aspects of the contexts within which entrepreneurial behaviour by NMHVs occurs.

The extent of intrapreneurial behaviour by NMHVs and the conditions under which it thrives are difficult to extrapolate from a wider and more general literature on innovation and change. We have identified some groups, such as health visitors, where the culture of the professional role is to be entrepreneurial, although the extent to which hierarchical organisations support or inhibit the entrepreneurial activities may be variable. We hypothesise that the public sector organisations are more likely to support intrapreneurial NMHV activity when it coincides with other aims or is supported by central government policy and ring-fenced monies.

We have identified a wide range of NMHV entrepreneurial behaviour in indirect health services and in direct patient care. However, the numbers of entrepreneurial NMHVs appears small in comparison to the scale of those registered as NMHVs or when compared to other professionals or business people operating in these sectors. The literature would suggest that many of these types of NMHVs
experience similar triggers, drivers and inhibitors to those presenting to women entrepreneurs, although there are more specific triggers for some NMHV groups. For example, independent midwives appear to have more specific barriers such as indemnity cover. Another example is the legislative changes that have allowed different types of service providers to hold NHS contracts, which has created opportunities for some NMHVs such as in primary care. These opportunities for NMHVs are incidental rather than a direct policy initiative aimed at NMHV business and, as our scoping demonstrates, a number of unanswered questions remain not just for NMHVs but also for health professionals as to the extent these opportunities will be successfully taken up.

The analysis by documented aspirational claims suggests that, while addressing patient choice featured as an aim for some NMHVs, other aspirational claims, such as for independence, autonomy and opportunity to use professional skills, featured more frequently. Even among these more frequently made claims, however, there was very little measurement of the actual impact of the entrepreneurial activity. As we noted, much of the literature we examined was not objective and leaves many gaps and questions. Throughout this section we have raised these issues and return to them at the end of the report after we have considered the findings from our expert seminars that are not considered in the literature.
Section 5 The expert seminars

A key objective of this study was to find out about the ways in which NMHVs are behaving entrepreneurially. As specified in the commissioning brief, our main approach to this task has been through scoping the relevant published and grey literatures. However, as in any area of activity, it was clear from the start that the literature would contain an incomplete account of what is actually going on. Even in fields that have been extensively researched, where written dissemination of findings is a normative expectation, it is well known that studies with favourable or significant results are more likely to be written up and published than those without such findings (Cronin and Sheldon, 2004; Song et al., 2000). In the present case, as the preceding section demonstrates, relatively little formal research has been performed. Behaving entrepreneurially is something people do, but they may have neither the time nor the motivation to write about it unless there is a good reason, such as something successful to celebrate. Consequently, those accounts that do find their way into the literature tend to be selective, both in the aspects of entrepreneurship that they cover and in how they are discussed. The prevalence of ‘hero’ literature in this field, as noted earlier, is a case in point.

The two expert seminars that we held towards the end of the study provided some opportunity to triangulate the findings from the literature review. (Details of the procedure are given in Section 1 and a participant list is provided in Appendix 3.) The facilitated discussions enabled us both to test our emerging analysis, by confirming or challenging the findings we presented, and to extend the analysis, by raising new issues that did not feature in the literature we reviewed. In the event, much of what was said in the seminars did reflect and reinforce the picture obtained from the literature. Where seminar participants expressed views that confirmed, challenged, elaborated or illuminated issues identified in the literature, these views have been noted and incorporated at the relevant points in earlier sections. In a few cases, participants told us about examples of entrepreneurial activity that had not already been identified; these have been accounted for in the analysis. The present section focuses on those aspects of NMHV entrepreneurial behaviour and experience that emerged in the seminars as relevant to understanding the nature of this activity, but which have not been mentioned elsewhere in our review.

Some of the issues that arose in the seminars were not commented on either in the broader management literature on entrepreneurship (discussed in Section 2), nor in the material specifically relating to NMHV entrepreneurial activity (reviewed in Section 4). For example, while entrepreneurial activity has been characterised in the literature as ‘mouldbreaking’ and ‘risk-taking’ (Austin et al., 2006), less is
written about how those who act entrepreneurially view themselves. Most of the seminar participants clearly saw themselves as ‘different’ in some way from other people in the health service – ‘mavericks’ or ‘misfits’ who do not fit into boxes and who might be perceived by others as ‘mad’ for the risks they willingly took. Various accounts were given of the kinds of things they enjoy, including: exposure to different ways of thinking and new ideas; a variety of work; being their own boss; exercising their own judgement; and having the confidence, arrogance and self-belief to succeed.

As one person said:

“I remember when I was just, just qualified and two months later I was applying for a charge nurse post. And ... I was called to interview and they said, ‘well you’ve only just qualified,’ and I said, ‘but I can do it’. So they gave me a deputy charge post. So I was able to accelerate.”

And another participant confirmed:

“I did exactly the same thing. Really arrogant! Very arrogant. I knew what I wanted and I knew what I didn’t want to do.”

This sense of exceptionality may help explain how these individuals overcame various factors that they identified as liable to prevent other people working in the NHS from leaving it for independent practice or, having made the move, from remaining outside. As already noted, there are many pull and push factors mentioned in the literature that may set people off down an entrepreneurial path, whose significance our participants confirmed. These include, for example, the ambition to innovate, the perception that opportunities for individual creativity are severely limited within the NHS and the belief that real change can therefore only be achieved by stepping outside. However, much less is written on the reasons why people may feel unable to embark on such a route. The main ‘restraining’ features that make the NHS tough to leave were identified in the seminars. The first such factor was the worry that they would not know how to function effectively outside the public sector. For example, one participant felt that they lacked the commercial knowledge that would be needed to move out of the NHS and set up independently:

“... even though I come from a family of business ... my father was in business, my brothers too ... I lived with this – them talking profit margins and all of this – but I trained as a nurse, I trained in the public sector and I have the wish to provide the best care I can. And while I always would fit myself into the organisational entrepreneur – I would push the boundaries – but within the safety of an organisation. And that’s how those of us that do that get so frustrated, because I don’t know how to make that next step.”

A second restraining factor that was widely acknowledged is the protection the NHS provides for its employees. As one person noted, ‘inside the NHS it’s the organisation that takes the risk’, and participants saw this as something that an entrepreneur must have courage to relinquish. By the same token, the NHS was seen as offering the back-up of a secure respite if things went wrong on the
outside. Some participants talked about having worked entrepreneurially, but not in a 'sustainable’ way – either for their own well-being or that of the project they were working on – and so they had gone back to the NHS. Going back in, albeit perhaps temporarily, was described as 'giving you the opportunity to recover’ and 'the space to think again’. Because of this option of return, particularly for those with clinical skills that are in short supply, NMHV entrepreneurial careers in the UK context may have more of the nature of a 'revolving door’ than the serial progression described earlier as characteristic of entrepreneurs in some other contexts.

Besides these deterrents to breaking out of the NHS, other aspects of the current climate were noted as diminishing still further the already limited opportunities for intrapreneurial behaviour while remaining inside, and thereby preventing people from 'cutting their teeth’ or obtaining a 'taster' of innovation. In particular, repeated service restructuring was seen as demoralising and discouraging, because any new venture was likely to be cut short. The frequent reshuffling of middle managers that accompanies continuous reform was also highlighted as an impediment, because:

“How do you sell your ideas, products, services if the people who have the authority to say 'yes' keep changing? How do you get to 'yes' when the person says, 'maybe’ and then you think you're going to get them to ‘yes’, and then – 'oh, hello, who are you?”

Other restraining factors identified were associated with the professional, rather than organisational, context of health care practice. Some of these factors are mentioned in the literature and have already been referred to. For example, participants commented on a perceived lack of confidence and unwillingness to take risks among NMHV practitioners, which they attributed to professional socialisation. Further problems not alluded to in the literature included the difficulty of gaining space to develop entrepreneurial activities in an environment already hedged in by established interest groups in which medicine dominates. In primary care, for example, it was observed that while the GMS contract should, theoretically, have opened up new opportunities for NMHV entrepreneurial activity, it had not actually done so. Various explanations were suggested, for example:

- Rather than working collaboratively, professional groups often block each other’s options in order to defend their own territory. Thus GPs try to block encroachment by nurses.
- The GP practice model is taken as a given and so prevents other developments emerging.

The BMA was also cited as a significant obstacle because it sets down conditions of employment for doctors and is very inflexible about what is done. One further limiting factor associated with the professional context was the fact that the NMHV workforce in the NHS has an expectation of good occupational pensions. Against this, the need to
organise a private pension if one became independent was seen as a significant deterrent.

There were also some issues discussed in the seminars that do feature in the broader literature on entrepreneurial behaviour, but were not alluded to in the NMHV literature reviewed. One such issue concerns people’s motives for working entrepreneurially. As discussed earlier, various claims are made in the NHMV literature about why people undertake these activities. These claims fell within four categories – professional, financial, mercantile and empathetic. Within the literature, financial reasons were mentioned least often and making money hardly featured at all. However, in the seminars there was general agreement that making money was a significant aim, though not necessarily the main objective,

‘As I’ve got on, and eight years down the line, and I’m earning quite substantially, a lot of, more of it, is motivation to earn. But it’s all still about developing people and … actually helping other people.’

For a minority of participants, financial gain was acknowledged as a key driver:

‘Well I have to say I work seven days a week. I work seven days a week every week. I’m on call 24 hours a day unless I have a holiday. And the thing that motivates me, that drives me, is the money.’

Participants suggested that this element might be missing from the literature because it is not seen as an appropriate motive to admit to, or alternatively because it is taken as given, and is therefore not necessary to acknowledge.

When talking from their own experience about the skills and support needed to function successfully as entrepreneurs, seminar participants reiterated many of the issues raised in the literature but also identified some additional topics. The acquisition of business skills and contacts was seen as crucial (as also acknowledged by the RCN Congress in its 2006 resolution to develop practical support for nurses working as entrepreneurs [RCN, 2006a]). Participants confirmed the value of formal business networks for women, as highlighted in the literature on women as entrepreneurs, and of more generic networks, such as the Federation of Small Businesses and Business in the Community. They also emphasised the importance of mobilising informal connections to access additional skills and contacts, for example, ‘the lawyer that lives next door’ and ‘the doctor who happens to be in the Department of Health, who lives down the road’. Such networking was seen to demand a rather different type of courage than was usually required in NMHV professional work. One participant recalled having behaved like ‘a complete tart’, when originally starting up in business, ‘always asking somebody a favour’. Others identified the need for acute ‘political’ skills to negotiate across conventional organisational and professional boundaries and to establish the relationships necessary to facilitate their work. ‘Political’ skills were particularly useful in roles, such as health visiting, where the job depended on
establishing links with agencies in the local community beyond the NHS and formal health care.

An important additional role of all these different types of networks was to counteract and protect against the isolation identified in the literature and confirmed by seminar participants as a potential downside of independent entrepreneurial practice. This ‘professional loneliness’ was widely experienced, and was seen as a key reason why some NMHV entrepreneurs return to working in the NHS. It was perceived to be a particular hazard for certain groups, such as aesthetic nurses, who risk ostracism by the rest of the nursing profession for the ‘unworthy’ nature of the work they did (dealing with Botox, etc.), despite the existence of a clear market for their services.

As mentioned at the start of this section, much of what was said in the seminars confirmed and reinforced the findings of this scoping study from other sources. In many respects, the participants echoed the upbeat tenor of much of the literature reviewed, being very positive about their experiences of entrepreneurial activities and the actual and potential contribution of this type of work. The present section has focused specifically on those areas discussed by participants that have not been covered elsewhere and, thus, it paints a slightly different picture. Specifically it draws attention to some of the difficulties and challenges that may prevent people embarking on, succeeding in or continuing with NMHV entrepreneurial practice in the present context. It is important to take account of this more cautionary perspective when considering areas for further research, especially if there is a continuing presumption within policy that entrepreneurial behaviour is something to encourage.
Section 6  Summary and discussion of findings, limitations and questions for further research

This section begins by outlining the main findings of this scoping exercise and discusses them in the context of current health policy and the organisational context in England. Next, the limitations of the scoping are identified. Finally, questions for further research that have been raised by this study are identified. The research questions are grouped into themes and each is linked to the relevant section of the report.

6.1 Summary of findings and today’s context

Since the main part of this study was undertaken (September 2005 to April 2006) the effects of major and unanticipated financial shortages within the NHS have given rise to new priorities in the day to day running of the service. Debts of between £600m and £700m have been predicted for the past financial year, and some 7000 NHS jobs were lost in March and April 2006, with the RCN predicting that up to 13,000 more would go (BBC News Online, 2006). At the time, the health secretary blamed poor financial management by a small proportion of NHS trusts for the debts. Her critics, however, claimed that government reforms involving miscalculation of the salary costs for NHS staff were likely to be the real cause (Batty, 2006). This view is supported by the Department of Health’s subsequent announcement that new contracts for doctors and nurses had cost £610m more than expected (Batty, 2006). We have witnessed a significant change regarding nursing recruitment, moving from the ‘crisis’ of shortages in 2005 to redundancies and a lack of jobs, according to the RCN, for 4 out of 5 nursing graduates within 6 months of qualifying, as the most overspent NHS trusts have been required to balance their books within the financial year (RCN, 2006b).

In the quickly changing NHS, it is hard to predict how such financial problems might interact with the promotion of nurse entrepreneurs by the government and with the forces (such as redundancy) that lead individual nurses to consider setting up in enterprise. Interest in the concept of nurse entrepreneurship has continued, to date at least, within this new context. At the RCN’s Congress in April 2006, a resolution submitted by nurse executives called for that organisation to develop practical support for nurses working as entrepreneurs. (The Nurse Entrepreneurs Group is a sub-group of the RCN Nurse Managers Forum.) A summary of the debate (RCN, 2006a) reveals discussion of the same issues raised within the literature and by the participants discussed in this report. For example, the possibility of a contradiction
between the motivation to make a profit and the motivation to provide ‘good care’, and the frustration of nurses trying to deliver a service in a satisfying way within the constraints of the NHS. The motion met with the support of the delegates.

In July 2006, a special issue of the journal Primary Health Care (Duffin, 2006) included a journalist-written feature on nurses and social enterprise, including reports of the Health Secretary’s promotion of the notion through her praise of a number of the initiatives already detailed in this report. The feature itself is even-handed, discussing the possible negative implications of, for example, the failure of the Department of Health to fund a second cohort of students on the course at the Skoll Centre for Social Entrepreneurship in Oxford discussed in our report. It also brings up the implications of opening up a market for health care provision without special support for enterprises newly formed by nurses. This could lead, the article suggests, to more health care being provided by large corporations, and the failure of smaller, potentially nurse-led initiatives to penetrate this market. Other problems highlighted for nurse-led enterprises included viability, sustainability, workforce security and pension issues.

Not only do these issues remain unresolved, but also there is sustained opposition from within both the NHS workforce (e.g. the industrial action over the proposed move of NHS logistical activities to the private company DHL) and the ranks of the Labour government. Despite these issues, the current administration continues to promote contestability and plurality of health care provision, and to challenge the more traditional ‘monolithic provider’ models of health and social care. Interestingly, these moves are being challenged by the RCN (see Section 4) at the same time as groups within that organisation are working to encourage growth in the activities of nurse entrepreneurs. Social enterprise provision is being particularly promoted as an appropriate model for care delivery, as it is said to allow great flexibility and innovation in addition to adding social value. It is considered by some to mirror many of the NHS values of patient-centredness and humanity of delivery. In terms of triggers to move into entrepreneurial behaviour, the promotion of social enterprise may well act as such a trigger, particularly for NMHVs in primary care, possibly in combination with the growing employment insecurity already mentioned. It should be remembered, however, that a social enterprise model of health care delivery is not necessarily new. Nurses in public health have been involved in these types of activities for many years, but only a few select examples are cited in the press, such as the nurse partnerships at Cuckoo Lane and Tipton practices or not for profit organisations, such as Surrey Health.

The Social Enterprise Coalition (www.socialenterprise.org.uk) also actively promotes the role of social enterprises in the delivery of public services, claiming that they bring together the best of the public and private sectors, the drive of business and a public service ethos. The
Social Enterprise Coalition’s contacts with government are close. For example, it has recently published a pamphlet by the Health Secretary, Patricia Hewitt, which sets out the advantages of involving social enterprises in the delivery of health care (Hewitt, 2006). Plurality of provider in primary and community care is particularly highlighted in this pamphlet and it also gives an indication of the present government’s vision for the future of the UK health service. To support this policy, NHS Networks has appealed for examples of commissioning of health and well-being services jointly with other agencies and from the third sector (such as voluntary, community or self-help organisations, or social enterprises) (NHS Networks, 2006). The advent of primary care commissioning clearly enables and promotes such diversity of provider, as previously discussed in this report (see Section 3).

This study has provided a conceptual map of the types of intra- and entrepreneurial activities engaged in by NMHV (Section 4). Although we found a range of NMHV entrepreneurial activity in the UK, it represents only a very small proportion of the NMHV and former NMHV engaged in these types of activities, which is also the case for most of the international literature. There are some sectors where this situation is reversed, such as midwives in the Netherlands.

There is only modest agreement over the meaning of the term ‘entrepreneur’ in business and management literature. This does not help an understanding of the term ‘nurse entrepreneur’. In some UK policy articulations, the term ‘nurse entrepreneur’ is used loosely, is ideological and the examples given are often more accurately described as organisational flexibility or nurse substitution for medical roles.

The international literature on nurse entrepreneurs uses the term interchangeably with enterprise in some countries or uses completely different terms to describe self-employed nurses and midwives or business owners (see Sections 2 and 4). Informants within the expert seminars were more comfortable with adverb entrepreneurial, than the noun entrepreneur (see Section 4.1).

The scoping exercise took a broad view of definitions in order to include rather than exclude activities (Sections 1 and 2). However, it was noted that there were challenges in dealing with the overlap with literature on innovation and change (Sections 1 and 4).

The UK scoping was analysed by type of activity (Section 4.4). It was noted that certain groups of NMHVs, such as those with public health roles and some clinical specialist roles, are more likely to be intrapreneurial. Consideration was given to the types of organisation or environment that might support such behaviour and to what extent any individual in an organisation was entrepreneurial in isolation from a wider group of people offering permission, support or resources (Section 4.4.3). Entrepreneurial NMHV activities were identified that indirectly contributed to health care including knowledge transfer.
through training and consultancy, invention of health care products, and provision of infrastructure services to health care, and self-employed and small business provision of direct health care services (Section 4.4.4).

Some recent policy changes in the commissioning of NHS primary care services and the creation of a supply-side market through encouraging third-sector health and social care enterprise make new forms of NMHV entrepreneurial and business activity possible. Section 4 documents the limited extent of this type of activity by NMHVs at present, although in an environment with rapidly changing policy and policy implementation, there is potential for this picture to change. It is not clear to what extent NMHVs will move from being employees of the NHS or general practice to being nascent entrepreneurs as employers in new types of social enterprise business or as business partners in general practice. Nor is it clear how nascent NMHV entrepreneurs will fare in competition for contracts in environments where many more entrepreneurs and businesses are established and when competing against the large corporations that are becoming involved in tendering for this new business opportunity. We would suggest that these types of issues can only be understood in the broader context of other health professional groups, rather than focusing on NMHVs in isolation.

It is noteworthy that many NMHV entrepreneurs who were either self-employed or employers had close relationships with the NHS. For some this was the source of their business, while others reverted to temporary employment when income levels dropped, moving out again because of dissatisfaction with the constraints of the NHS, and moving back in when self-employment was precarious. One expert informant described the NHS as ‘the mothership’, illustrating a perception of the NHS as a safety net against entrepreneurial risk. Therefore, the career paths of NMHV entrepreneurs may be complex. Recent nurse redundancies and uncertain career prospects for nurses may lead to many considering self-employment on the edges of the NHS or well beyond it.

We are uncertain whether levels of NMHV entrepreneurial activity are likely to increase in the future. Theoretically, at least, the rising levels of nurse redundancy that we are currently witnessing will create a larger pool of potential entrepreneurs. The expert seminars tended to indicate that those NMHVs who have left the NHS to set up in business on their own, in a largely hostile and unfavourable climate, are atypical of the greater NMHV workforce as a whole – exhibiting unusual persistence, individuality, risk-taking and willingness to ‘put their head above the parapet’. As these are classic characteristics associated with entrepreneurs this may be unsurprising, but their atypicality raises questions about the likelihood of increased numbers of NMHVs behaving entrepreneurially in this sector, which future research would need to explore. In addition, the great majority of the pool of potential NMHV entrepreneurs are women, and women take
different routes, respond to different types of triggers, seize different types of business opportunities and experience different barriers to male entrepreneurs (Section 2.6.4).

The connection between NMHV entrepreneurial activity and patient choice does not appear to be strong (Section 4.6) with the possible exception of independent midwifery. Increasing patient choice was stated as an aspiration in 20% of the documents we analysed. Aspirations concerning autonomy of practice and professional accomplishment were cited in approximately 55% of these documents. Financial motivations are not prominent in the literature but our seminar participants suggested that this may be misleading because, they believed, talk of the profit motive is unacceptable within NMHV culture. It was noticeable that the documented aspirations of the sample of intrapreneurial NMHVs were focused on addressing issues of equity in provision and access for those poorly served by current arrangements – a policy imperative not explicitly linked with the patient choice agenda though present in other policy.

There is very little actual measurement (and therefore evidence) of the outcomes of entrepreneurial activity (Section 4.6.1). If entrepreneurialism is an area to be encouraged, good process and outcome evaluations are needed to find out what works – for example the importance of networks for entrepreneurs and intrapreneurs — as well as what does not work — and the circumstances in which NMHV entrepreneurialism is successful.

The theme of choice has the longest history in midwifery, with policy in the early 1990s encouraging choice for women in childbirth. However, that increased choice is confined to a small number of clients, geographical access is restricted and, currently, user fees restrict choice to those who can afford to pay. While there are independent midwives, there has not been an explosion in their numbers because of the difficulties they face. While they may have gained in terms of professional autonomy, they have had to contend with barriers, such as the difficulty of getting affordable professional indemnity cover. They have also struggled with the hospital interface and alienation from other professional groups. Independent midwifery has a greater share of voice in the literature, although, as with the primary care literature, much is ‘hero’ reporting and little is written about the measurement of outcomes. Further investigation of the midwifery experience might identify lessons for application to other professional groups.

Both the literature and our expert seminars revealed some of the obstacles to becoming entrepreneurial and surviving successfully in those roles, including:

- the importance of the wider context
- the NHS in general and its present state of flux
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- the wider professional environment – both NMHV socialisation and NMHV work take place within the power structures of the health sector overall.

If the NHS itself changes (e.g. becomes less secure and supportive), then the balance of risk/safety and cost/benefit for staying in it versus leaving to be an entrepreneur will also change.

6.1.1 Policy implications of the findings

**Intrapreneurship**

Some intrapreneurial NMHV are addressing patient and population group health care needs that are poorly served by current arrangements. Intrapreneurial activity is difficult to distinguish from innovative activity, but intrapreneurial activity is most apparent in groups who are given organisational permission to innovate and where command and control hierarchies are less apparent. At the meso level of policy-making, consideration needs to be given to how organisational structures can support rather than inhibit intrapreneurial behaviour that addresses both patient need and choice.

**Primary care commissioning**

If NMHV entrepreneurs are to be encouraged as one mechanism for promoting patient choice, then specific treatment of NMHV entrepreneurial activity in the face of competition from large corporations may be required. Further research into the full extent of new NMHV entrepreneurial activity in response to recent changes in primary care commissioning is required.

NMHV entrepreneurs are atypical of NMHVs as a whole: if NMHV entrepreneurs are to be encouraged, attention needs to be paid to recruiting into the professions those with entrepreneurial leanings and then to provide support, skills training and network-building opportunities for this group.

**Change in the NHS and entrepreneurial activity**

Continued change and restructuring, as well as current drives to reduce expenditure, in the NHS are likely to inhibit entrepreneurial activity within it and on its edges.

6.2 Limitations of the study

We acknowledge two limitations within this scoping exercise. We primarily focused our work on areas where we already understood that NMHV entrepreneurial activity was likely to be predominant. In this way, aimed to gather the greatest amount of information within a relatively short study. This has led to a greater focus on primary care and midwifery literature. Accounts of NMHV entrepreneurial activity
within the acute care and mental health sectors were far less prominent and it is likely that there is unexamined activity in these sectors. While we addressed our brief, in that a comprehensive review was not required for this project, it may be that there is further material to be revealed by further empirical investigation.

The second limitation is a result of the character of the literature on NMHV entrepreneurialism itself (Section 4.1). Published literature provides only a partial account of any field of activity and this may be particularly evident within the topic of this scoping exercise. In scientific literature it is well accepted that a publication bias exists (Easterbrook et al., 1991) resulting in a lack of published accounts of negative findings (even though there is potentially much to learn from them). The literature on entrepreneurial activity shows a strong emphasis on the heroic and successful and it is therefore even more likely that accounts of failed enterprises will not be documented. Also, as our seminar participants reminded us, entrepreneurs tend to do rather than write, so there is likely to be more activity than literature. In addition to this, the great majority of the literature that we did review was not conventional research literature providing (or aiming to provide) reliable, objective and systematic information about its topic. Rather personal narratives and journalistic accounts predominated. At best, this limited the amount of information contained within the articles; at worst it meant that accounts were biased in ways that suited the purposes of the individual writers. It was because we recognised all of these problems with the literature that we ran the expert seminars. Talking to people involved in NMHV entrepreneurial activity helped us to triangulate the information collected from the literature by raising our awareness of its biases and gaps. We have used the findings of the seminars in the text of our report where they link to issues that are raised in the literature and to extend, illustrate, expand and challenge it.

### 6.3 Summary of research questions raised in this report

The following research questions have been drawn from our analysis of the literature and e-scoping (Section 4) and discussions in the expert seminars (Section 5) and our identification of the gaps in available knowledge. Their breadth illustrates the paucity of information currently available across a broad range of issues of interest in the policy arena. We would suggest that while most of the focus is on NMHVs, empirical study would be enhanced by opportunities for comparative analysis with other health professionals.

There are two major themes to the research questions raised by our research. The first theme concerns benchmarking and arises from the need to generate comprehensive knowledge about the current extent of NMHV entrepreneurial activity and its character. The second theme concerns investigations into the factors that are likely to encourage or
support entrepreneurial or intrapreneurial activity. In the absence of any good evidence, the focus of many of the suggested research questions is on establishing baseline information and these are grouped together as a theme. This should help to determine what kind of effectiveness research can be undertaken and what kind of judgments can be made about NMHV entrepreneur effectiveness and how they affect care, outcomes and organisational delivery. In addition, further research/policy consideration will be better illuminated by considering NMHVs in the wider context of other intra-/entrepreneurial health professionals.

6.3.1 Theme 1: benchmarking

Intrapreneurial NMHVs

Our policy analysis, literature review and the testimony of our expert panel all revealed a focus on the prominence of intrapreneurial activity by NHS employed nurses as a way that innovation could be developed. Also apparent, however, was the fragility of some of these initiatives in the face of withdrawal of funding or changes in employment of the instigators, meaning that any benefits were not sustainable. Therefore the following question is recommended for further research.

<table>
<thead>
<tr>
<th>Research question</th>
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<tr>
<td>• To what extent is any intrapreneurial activity in the NHS the result of one person’s activity, drive or motivation (Section 4.4.2)?</td>
</tr>
</tbody>
</table>

Entrepreneurial NMHVs

We know little about who NMHV entrepreneurs are. Knowing this could help to reveal the kind of support that they are likely to need if the Department of Health wishes to encourage such activity. Also, understanding their motivation will help policy-makers to ascertain how far the encouragement of NMHV entrepreneurs is likely to further the policy objective of the promotion of patient choice.

<table>
<thead>
<tr>
<th>Research questions</th>
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<tbody>
<tr>
<td>• What is the age profile of NMHVs moving into enterprise and how many years of health care experience do they typically have? (Section 4.4.4)</td>
</tr>
<tr>
<td>• To what extent does the NHS lose NMHVs with significant clinical expertise to enterprise during periods of organisational turbulence and downsizing, particularly during the present year? (As above; Section 5)</td>
</tr>
<tr>
<td>• To what extent do clinically and managerially experienced NMHV develop portfolios of different types of work and income streams? (As above)</td>
</tr>
<tr>
<td>• How do the career trajectories of male and female NMHV entrepreneurs compare? (Section 4.4.4; Section 2.6)</td>
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</table>
6.3.2 Theme 2: What factors encourage and support NMHV intrapreneurial and entrepreneurial activity?

**Intrapreneurial activity**

If the Department of Health wishes to promote NMHV entrepreneurs and intrapreneurial behaviour in order to further the aim of promoting patient choice or for other reasons, it is important to have an understanding of the organisational factors that are likely to promote this. The following research questions concern intrapreneurial activity.

**Research questions**

- What are the key features of an NHS organisation that supports intrapreneurial activity by NMHVs? (Section 4.4.2)
- What factors external to an NHS organisation are likely to support or inhibit intrapreneurial activity by NMHVs? (As above)
- Is there any link between the types of education, background and/or the level of seniority that support intrapreneurial behaviour by NMHVs? (As above; Section 5)
- To what extent do the relationships with doctors and other health professionals (and which types of relationships with which types of doctors and others) support or inhibit NMHV intrapreneurial behaviour? (As above; Section 3; Section 5)
- Do NMHV roles that have clearly defined focus and boundaries encourage intrapreneurial activity on behalf of their client groups? (Section 4.4.2)

**Entrepreneurial activity**

NMHV entrepreneurialism has been promoted at times as if it is an unproblematic way to improve services and increase patient choice. Our scoping, however, found that this was not always the case and that unforeseen obstacles to successful entrepreneurial behaviour existed. Would-be NMHVs speak of encountering some hostility from
Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

those within mainstream services. In addition, NMHV entrepreneurs seldom formally evaluate their impact, being more concerned with delivery issues. Therefore we know little about how effective – either clinically or in terms of achieving government policy objectives – the range of NMHV entrepreneurial activity is. To provide this information, we propose the following questions.

Research questions

- Are the failure rates of nascent NMHV entrepreneurs comparable to others setting up in business in the UK and what can we learn from ‘failed’ enterprises? (Section 4.4.4; Section 5)

- To what extent is there hostility within the NHS to NMHV entrepreneurialism and does this contribute to some failures? (As above)

- Can NMHV entrepreneurs be encouraged and enabled to evaluate their outcomes systematically? (Section 4.6.1)

To what extent does the use of NMHV qualifications aid or detract from entrepreneurial activities? (Section 4.4.4)

- To what extent do NMHV entrepreneurs create choice for patients or respond to known gaps in service provision? (Section 4.4.4)

- To what extent do entrepreneurial NMHVs have family or previous experience of the business world and to what extent do they have different personality traits to other NMHVs? (Section 4.4.4; Section 5)

- To what extent does the NHS encourage and support inventions by NMHVs and deal with issues such as intellectual property rights? (As above)

- What types of local and national level support, by which types of stakeholders, enable NMHVs to compete for contracts for mainstream NHS services? (Section 4.4.5)

- Are multidisciplinary tenders for APMS and SPMS contracts likely to be more successful than NMHV only tenders? (As above)

- Are the tenders offered by nurse led organisations for APMS and SPMS contracts different in any respect to those offered by other groups? (As above)

- To what extent do NMHV services directly paid for by the client offer something that is not available or not provided in an acceptable manner in the NHS? (As above)

- If a policy goal is to encourage more NMHV entrepreneurs, what additional support is needed? What is the environment for cultivating successful entrepreneurs? What are the education and training needs to contribute to a growth in NMHV entrepreneurial activity? To what extent can the skills (such as political skills) be learnt on a course like Skoll? (Section 2; Section 5)
What are the options for managing conflict of interest issues in relation to commercial confidentiality and the transfer out of (and back into) the NHS of entrepreneurial talent? How will this affect the cooperative versus competitive dynamic that such transitions imply? What lessons may be learnt from experience with the medical profession? (Section 5)
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Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

Appendix 1

The UK nursing, midwifery and health visiting workforce context

In 2005 there were 672,897 nurses, midwives and specialist community public health nurses registered with the Nursing and Midwifery Council (NMC), of whom:

- 503,728 (75%) were first-level registered nurses only
- 43,064 were registered as midwives (although only 32,745 submitted intention to practise [ITP] forms for 2005)
- 29,000 were registered as specialist community public health nurses[^17].

No one is allowed to practise as a nurse or midwife in the UK without registering with the NMC every 3 years. In addition, midwives have to submit an annual ITP form to the NMC.

The NMC statistical analysis showed that 89% of those registered were female (a 1% increase over 10 years), 60% were over the age of 40 and 77% resided in England (NMC, 2005). From 1996 to 2000 an average of 18,000 people joined the NMC register annually, increasing to 30,000 annual additions after 2000. Approximately 3% left the register annually between 1996 and 2005 (NMC, 2005).

In the UK, the majority of NMHVs are employed in the NHS. Approximately 437,000 (headcount) were employed in 2005[^18] in comparison to the estimated 58,000 full-time equivalent registered nurses and midwives employed in private hospitals, homes and clinics (data for 2000 in England and Scotland). A further 24,000 nurses were employed by general practices in England and Scotland[^19].

Characteristics of the NHS NMHV workforce

NMHVs form around 30% of the directly employed NHS workforce, although they make up the largest clinical group. The majority work in acute, elderly and general medicine specialities, as illustrated by the English data on professionally qualified NMHV depicted in Figure 3.

[^17]: From 2005, the specialist community public health nurse section of the NMC register includes health visitors, schools nurse and occupational health nurses who meet a set of competency criteria.

[^18]: All data in this section have been compiled from 2005 NHS workforce statistics collected by the NHS England Information Centre for Health and Social Care, the Information Services Division of NHS National Services Scotland, the Northern Ireland Health and Personal Social Services Information Analysis Directorate and the Statistical Directorate of the Welsh Assembly.

[^19]: Data not available for Wales or Northern Ireland.
Although the majority of nurses are female (89%), the distribution of male nurses varies between service areas, for example, 35% of nurses in the psychiatry services are male but only 1.3% are male in maternity services. The ratio also varies according to position in the organisational hierarchy. While overall 1 in 10 NMHV are men, 1 in 5 nurse manager posts are held by men, increasing to 1 in 2 in services that employ more men (e.g. community psychiatry services).

The age distribution also varies between sectors. Only 12% of the total number of NMHVs working NHS are aged under 30, this proportion rises to 15% in the acute, elderly and general medicine sector and drops to 10% in maternity services and to 6% for registered nurses working in the community. The age distribution curve skews further in some segments of the primary care nursing workforce, where 70% of health visitors and district nurse team leaders are aged over 40.

Many NMHV work part time in the NHS, as evidenced by the difference between the head count and the number of full-time equivalents. However, this too varies between sector and gender. For example, in Northern Ireland, only 56% of nurses work full-time hours in the NHS, but this rises to 89% in the mental health services and 74% in the district nursing services. It is also noted that 93% of all male nurses worked full-time hours.

The self-declared ethnic background of the NMHV workforce is incomplete. In England, ethnic background is unknown for about 20% of NMHVs. Of those whose ethnic background is known, 19% are from minority ethnic groups, of which the two largest groups are Black or Black British (over 23,000) and Asian and British Asian (over 21,000). This contrasts with the NHS workforce as a whole, in which 8% of staff
come from ethnic minorities and the workforce of the UK economy as a whole (6.7%). As with age and sex there is variation between service areas and positions in the hierarchy. About 20% of registered nurses, 12% of midwives and 10% of health visitors are from ethnic minority backgrounds. They are less likely to be represented in the positions of seniority, with 6% of modern matrons and 7% of nurse managers coming from ethnic minority backgrounds.

Comprehensive data on turnover and exit from the NHS or NMHV workforce is harder to obtain. The Office of Manpower Economics undertakes an annual workforce survey as part of gathering evidence for the Pay Review Body but points to the high level of incomplete data as a reason to treat the survey results with caution. In 2005, it reported from 164 trusts in England and Wales and identified that the turnover rate, i.e. those leaving as a proportion of staff in post, was 11% in the NHS (England and Wales). Of these, about 40% had no departure reason recorded, but 9% were retirements, 8% were to employment outside the NHS and 22% were recorded as ‘other’, including redundancy, career break and personal reasons.

**Characteristics of nurses employed in the UK independent health care sector**

Information on the characteristics and demography of the NMHV not directly employed by the NHS is more difficult to obtain. While there broad data are available on numbers of practice nurses employed by general practice, no recent demographic data exist. The numbers of practice nurses, however, has grown enormously since the early 1990s because legislation, such as the GP contract, offered enhanced financial incentives to GPs to employ them. There were 115 independent midwives registered with the Independent Midwives Association as of 2006.

The demographic profile of the NMHVs in the UK indicates that it is necessary to understand the literature specifically about women entrepreneurs (see Section 3).
Appendix 2

Text of invitation to respond to e-scoping

Dear E group members

Subject: NHS funded Service Delivery and Organisation (SDO) Scoping Project on Nurse, Midwife and Health Visitor Entrepreneurs and Patient Choice

As part of the above scoping study we are investigating past and current entrepreneurial activity among nurses, midwives and health visitors. The aim is to build a picture of the extent and types of entrepreneurial activities that NMHV’s are involved in and to explore the implications for patient choice. By the term ‘entrepreneur’ we mean anyone who has recognised a nursing-related opportunity to start up something new, has actioned that idea and seen it grow and develop either within the NHS or outside of the NHS. We know that these types of activities are not new for many NMHV’s but feel few have been disseminated through conventional published literature.

We would be delighted to hear from anyone who is or has been involved in such initiatives.

Best wishes

Kathy Davis/Rachel Locke
Research Fellow
Tel 0207 288 3323
Email: k.davis@pcps.ucl.ac.uk

This is a collaborative project. Michael Traynor is the Principal Investigator from the Middlesex University. The team also includes: Vari Drennan from the Primary Care Nursing Research Unit, UCL, Claire Goodman from the University of Hertfordshire, Charlotte Humphrey, Susan Murray and Rachel Locke from King’s College London and Annabelle Marks from the Middlesex University Business School.
Appendix 3

Expert Seminar 3 April 2006

Participants’ list

<table>
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<tr>
<th>Participants</th>
<th>Facilitators</th>
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<tbody>
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<td>Middlesex University</td>
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<td>Director of company that runs as an APMS</td>
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<td><strong>Martin Hunt</strong></td>
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<td>Head of Service Development at the MS Society</td>
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<td>Care, Department of Health</td>
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<td><strong>Debra Sharu</strong></td>
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<td>Director, Practitioner Development UK Ltd</td>
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<tr>
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<td>School of Nursing and Midwifery</td>
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<td><strong>Annabelle Mark</strong></td>
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<td>Professor of Healthcare Organisation and</td>
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<td>Director NHS Human Resource Management Training Scheme</td>
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Appendix 4

E-scoping: List of websites searched

Nursing related

UK

- The Royal College of Nursing UK
  http://www.rcn.org.uk/

International

- International Council of Nurses
  http://www.icn.ch/guidelines.htm
- The Nurse Innovations Database
  http://www.icn.ch/innovations/
- The Nurses in Business Organisation
  http://www.nnba.net/index.htm
- European Nursing Leadership Foundation
  www.nursingleadership.org.uk/home.htm
- The National Association of Independent Nurses
  http://www.independentrn.com/
- The Nurse Entrepreneur Network
  http://www.nurse-entrepreneur-network.com
- The Nurses Medscape website
  http://www.medscape.com
- University of Tennessee
  http://www.utmem.edu/nursing

Entrepreneurship

General

- World Health Organization Regional Office for Europe: Highlights on health
  http://www.euro.who.int/epise/main/who/progs/chhfra/home
- The Global Entrepreneurship Monitor Programme
  http://forum.london.edu/lbspress.nsf/AllDocs/6866DDA3BCF5ED80256F90003968DB/$File/GEM+Global.pdf
- Erasmus Research Institute of Management – The ERIM Report Series: Explaining Female and Male Entrepreneurship at the Country Level
  https://ep.eur.nl/handle/1765/7172
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- Greenleaf Centre for Servant-Leadership
  http://www.greenleaf.org/leadership/servant-leadership/What-is-Servant-Leadership.html

Female entrepreneurship

UK

- The British Association of Women Entrepreneurs
  http://www.baew-uk.org/
- Prowess – UK association of organisations and individuals who support women to start and grow businesses
  http://www.prowess.org.uk/default.asp
- Everywoman UK – leading provider of valuable, practical and relevant services to support women in business
  http://www.everywoman.co.uk/
- Department of Trade and Industry Small Business Service: Promoting Female Entrepreneurship
  http://www.dti.gov.uk
- Barclays Small Business Survey Women in Business 2004
  www.barclays.co.uk/bb/surveys
- British Chamber of Commerce – Women’s Enterprise Steering: Group Achieving The Vision Female Entrepreneurship
  http://www.chamberonline.co.uk/policy/issues/women/womens_entrepreneurship.pdf
- The National Foundation for Women Business Owners
  www.nfwbo.org
- Women into the Network (WIN)
  www.networkingwomen.co.uk
- Scottish Business Women
  www.scottishbusinesswomen.com

International

- Development Fund for Women UNIFEM Gender Fact Sheet No.4.
  http://www.unifem.org/
- EUROPA European Industry and Enterprise – The European Network to Promote Women’s entrepreneurship (WES)
  http://europa.eu.int/comm/enterprise/entrepreneurship/craft/craft-women/wes.htm
- Women Entrepreneurs
  http://europa.eu.int/comm/enterprise/entrepreneurship/craft/craft-women/womens-activities.htm
- Equal Opportunities for Women
  http://europa.eu.int/comm/employment_social/genderequality/index_en.html
- Women in Business and Decision-making – A Survey of Women Entrepreneurs co-funded by the European Commission
Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review


- Center for Women’s Research (formerly the Foundation for Women Business owners)

Social entrepreneurship

- Ashoka, developed by Bill Drayton to develop and legitimise the profession of social entrepreneurship
  http://www.ashoka.org/fellows/social_entrepreneur.cfm
- The Kaufmann Foundation – Diana project

Other

- National Statistics: Growth in self-employment in the UK
- International Labour Organization Bureau of Statistics
  http://laborsta.ilo.org/

Footnotes

- Ashoka is an international organisation that develops social entrepreneurial activities worldwide.
- Founded in September 1999, Everywoman Ltd launched its first service, the website www.everywoman.co.uk. It was the first interactive website for women in the UK and is now the leading online network for women starting or growing a business. With over 100,000 signed-up members, everywoman.co.uk provides users with relevant information, appropriate services and additional resources.
- Prowess is a UK network of organisations and individuals who support the growth of women’s business ownership. Prowess has over 180 members who support 100,000 women each year to start 10,000 new businesses that contribute an additional £1.5 billion to the economy.
- The Global Entrepreneurship Monitor (GEM) research programme is an annual assessment of the national level of entrepreneurial activity, which was established in 1997. GEM is the world’s largest and longest-standing study of entrepreneurial activity and is scaled on population not labour force in the formal sector rather than the informal sector. The results of GEM data analyses are used as key benchmarking indicators by regional, national and supranational authorities worldwide. GEM surveys analyse total entrepreneurial activity (TEA), defined as the share of adults in the population aged 18–64 who are actively involved in starting a new business or managing a business less than 42 months old. Data are captured for two categories: the nascent entrepreneur,
who is an individual who has taken action and created a new business in the past year and expects to share ownership but has not yet paid salaries and wages for more than 3 months, and the owner/manager of a new firm that has paid salaries and wages for more than 3 months but is less than 42 months old.

- The British Chamber of Commerce/GEM report, *Female entrepreneurship 2004: An overview of the entrepreneurial landscape in relation to women in the UK*, contains in-depth analysis of 3 years of data from GEM and more than 60 case studies from the Chamber of Commerce network.

- In the USA, The Diana Project (sponsored by the Kauffman Foundation) is a multi-university, multi-year project that is specifically dedicated to the study of women business owners and business growth

- The European Network to promote Women’s Entrepreneurship (WES) is a network created on a Swedish initiative in October 1998 and launched officially in June 2000. This network is composed of 16 members, from all the countries of the European Union, except Luxembourg, plus Iceland and Norway. The delegates in the network represent central national governments and institutions with the responsibility to promote female entrepreneurship.

- The British Association of Women Entrepreneurs (BAWE) is the British affiliate of Les Femmes Chefs d’Enterprises Mondiales (FCEM), one of 30 affiliated countries from 5 continents linked to all chambers of commerce. The association has been in existence for over 50 years. Its aim is to bring together women qualified to be called ‘Heads of Business’ (women who control or run a company, whatever its size, and crucially have capital at risk and are financially responsible for their business commitments).
Appendix 5

On-line resources for women’s entrepreneurship

- Development Fund for Women UNIFEM Gender Fact Sheet No.4  
  http://www.unifem.org/
- The Cambridge- MIT Institute  
  www.cambridge-mit.org/cgi-bin/default.pl?SSSID=572
  http://forum.london.edu/lbspress.nsf/AllDocs/6866DDA3BBCF5EDB80256F9000396DB/$File/GEM+Global.pdf
- Global Entrepreneurship Monitor (GEM)  
  http://forum.london.edu/lbspress.nsf/AllDocs/6866DDA3BBCF5EDB80256F9000396DB/$File/GEM+Global.pdf
- 2005 Gender Divide Report  
- National Statistics Online  
- The Europa Enterprise and Industry arm of the European Commission  
  http://europa.eu.int/comm/enterprise/entrepreneurship/craft/craft-women/women-dgentr-activities.htm
- US Centre for Women’s Business Research  
  http://www.womensbusinessresearch.org/topfacts.html  
- Prowess  
  http://www.prowess.org.uk/start/inspiration.asp  
- Small Business Survey  
- Everywoman.co.uk  
  http://www.everywoman.co.uk  
  http://www.everywoman.co.uk/aboutus/WIBTheFacts_130803.doc
Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

  http://forum.london.edu/lbspress.nsf/AllDocs/6866DDA3BB
  CF5EDB80256F90003968DB/$File/GEM+Global.pdf

  http://www.eurochambres.be/PDF/pdf_women_network/Wi
  B%20Women%20final.pdf

- Global Women Inventors and Innovators network
  http://www.gwiin.com/

- Women’s Entrepreneurship development
  rog=Sandp_subprog=WE

- United Nations Economic Commission for Europe Fact Sheet 4
  http://www.unece.org/press/pr2004/04gen_n06e.htm

- Organisation for Economic Co-Operation and Development
  http://thesius.sourceoecd.org/vl=7386389/cl=11/nw=1/rpsv/cgi-
  bin/fulltextew.pl?rpsv=ij/oecdthemes/9998010x/v2001n19/s1/p
  11.idx

- National Statistics Online Growth in Self-employment
Appendix 6

Overview of the primary care contracting routes available to PCTs to commission or provide primary care medical services

The new general medical services (GMS), personal medical services (PMS), primary care trust led medical services (PCTMS) and alternative provider medical services (APMS) are the four main UK contracting routes. These services provide a strategic framework to enable PCTs to plan, commission and develop high-quality primary medical services. Through these routes, PCTs have considerable flexibility to develop services that offer greater patient choice, improved capacity and access, and can help to fulfil the needs of a specific population. This approach also allows the development of innovative approaches to service delivery enabling PCTs to commission medical services from a range of providers, including the independent sector, voluntary sector and not-for-profit organisations. These contracting arrangements are briefly summarised below.

- GMS is a practice-based contracting arrangement that rewards primary care health professionals for achieving designated outcomes, rather than for the numbers of patients treated.
- PMS provides an alternative local arrangement to the national GMS and offers greater service provider flexibility.
- Specialist medical services (SPMS) is a newer model within the PMS framework that was introduced in 2004. This type of contracting arrangement is designed to enable providers other than GPs to address needs not being fully met by other PMS options, thereby expanding capacity and reducing inequality particularly among disadvantaged or vulnerable groups. SPMS contractors are generally not expected to deliver the totality of essential PMS and contracts can only be entered into by those qualified to hold PMS contracts, thereby allowing staff to retain NHS terms and conditions. Patients need not be registered with the provider to receive specialist care or core medical services. SPMS can be nurse-led or a group of primary or secondary care clinical practitioners, an NHS trust or a GP providing specialist care to patients other than their registered patients.
- PCTMS is a contracting arrangement that enables PCTs themselves to employ staff directly. The PCT can employ full-time staff to provide a full range of services, or can employ staff on a sessional or part-time basis.
- APMS is a flexible contracting route, introduced in April 2004, that gives PCTs powers to contract for a range of PMS from a variety of
Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

providers and runs alongside other primary medical care contracting routes.

Further information on NHS primary care contracting is available as detailed below:

- Principal website
  Department of Health, Primary Care Contracting website
  http://www.dh.gov.uk

- GMS/PMS
  http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareContracting/fs/en

- APMS
  http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareContracting/APMS/fs/en

- SPMS
  http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareContracting/PMS/PMSArticle/fs/en?CONTENT_ID=4125644andchk=1YPbQD
Appendix 7

Summary details of references

Table 7 Employees acting in intrapreneurial and social intrapreneurial ways: Quasi-autonomous roles

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Reference</th>
<th>Nurse</th>
<th>The activity (date ordered)</th>
<th>Geographic location</th>
<th>Financial arrangements</th>
<th>Reported drivers</th>
<th>Reported barriers/inhibitors</th>
</tr>
</thead>
</table>
| 1       | Smy J. 2006. | Specialist community nurses and senior tenant housing support liaison | • A weekly drop-in centre  
• Started 1994 | Preston, Lancashire | Lancashire NHS Care Trust and nurse-led funding campaigns | • Improve health needs of marginalized people  
• Focus on single homeless  
• Expand current service and provide longer operating times | • No permanent base: moved three times  
• Financial resources |
<p>| 2       | Daniel K. 1998. | Managing team of community health | • The Ore Valley Community project: one of series of | Hastings, East Sussex | Initial funding (£4500) provided through QNI innovation award | • Tackle health inequalities and meet the disenfranchised, neglected and socially | Difficulties of consensus between HC managers making |</p>
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<tr>
<th>Ref No.</th>
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<th>The activity (date ordered)</th>
<th>Geographic location</th>
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<th>Reported barriers/ inhibitors</th>
</tr>
</thead>
</table>
| 1 | Community Practitioner 72: 117–8 | worker, HV and colleagues | initiatives as part of a new primary care infrastructure  
- enhanced by use of a ‘1066 Housing Association’ rent-free flat for 1 year  
- used a multi-agency approach to problem solving that included the residents of 3 deprived, council housing estates  
- Started 1998 | scheme | excluded health and social needs of women and older persons of 3 council estates identified in East Sussex Health report in 1995  
- Professional aspirations included satisfaction and professional development | decisions and the need for client consultation |
| 2 | Journalist feature article  
Daniel K. 1999  
Banking on Success.  
Community Practitioner 72: 390  
News item | Community Practitioner 72: 390 |  |  |  |  |
Nurse-led teleconsultation service improves services for older patients.  
Primary Health Care 11: 6 | District nurse/health visitor team | Pioneering nurse-led teleconsultation service for older persons in rural communities combining screening and assessment and, if necessary, home visits | Hamlet, Angus region, NE Scotland | Tayside Primary Health Care Trust | Limitations of health care due to no medical practice or pharmacy services in the village  
- Optimism and opportunity to increase nurse role and scope of professional practice | GPs doubt of effectiveness of teleconsultation compared to face to face consultations  
- Scepticism that teleconsultations are a cost-
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<tbody>
<tr>
<td></td>
<td><strong>News item</strong></td>
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<td></td>
<td><em>Nursing Standard</em> 15: 33–8</td>
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<td><strong>Research</strong></td>
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<td></td>
<td><em>Nursing Standard</em> 15: 33–7,2–8</td>
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</table>

- Study commenced and evaluated in 1999

- A major patient benefit was not having to travel 6 miles to nearest GP surgery (patient choice/easing access to care)
- Reduced demands for GPs to be village based
- Ongoing difficulties faced by patients from foot and mouth outbreak
- Strength of system was nurses role as an intermediary, helping patients and doctors to understand different aspects of consultations
- Improved doctor/nurse communication leading to mutual learning and understanding

Effective measure offering low-cost non-doctor branch surgery
### Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

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<th>Reported barriers/ inhibitors</th>
</tr>
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<tbody>
<tr>
<td>4</td>
<td>Walker M, Levettk K. 2002. Community nursing innovation. <em>Journal of Community Nursing</em> 16: 4–6</td>
<td>Community nurses</td>
<td>• Collaborative pilot project with Age Concern to provide advice, illness prevention and referrals to other services, e.g. chiropodist, house-sitters, telephone alert systems  • Started April 2000 for period of 30 weeks</td>
<td>Northiam, Kent/Sussex border</td>
<td>Not stated</td>
<td>• Provide a rural area, proactive approach to practice in response to older people being reluctant to 'trouble' the doctor  • Community nurses aimed to prevent problems, improve communication, patient care and health care information for older people  • Expand nurse role</td>
<td>Not stated</td>
</tr>
<tr>
<td>5</td>
<td>Lane D. 2001. Setting up a sexual health clinic in a school. <em>Nursing Times</em> 97: 11–10</td>
<td>School nurse</td>
<td>• Collaborative pilot service linking school-based sex education with appropriate social services based in the school grounds; provided weekly sexual health clinic for youngsters</td>
<td>Sheffield</td>
<td>Not stated</td>
<td>• Reduce rates of unplanned teenage pregnancies and sexually transmitted diseases  • Improve access and availability of services within school environment in an area of social deprivation</td>
<td>• Controversy about provision of contraception and sex advice in school surroundings  • Prescribing of emergency contraception</td>
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</table>
### Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

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<th>Reported barriers/ inhibitors</th>
</tr>
</thead>
</table>
| 6       | Howard H. 2003. Asylum seekers and primary care                             | Specialist nurse practitioner and HV team                            | • MD homeless people, refugees and asylum seekers health care and training service that developed resources and a client checklist for GPs; client held records and nurse led assessment for newly arrived asylum seekers  
• Started March 2001 | Croydon, Surrey               | Not stated                                                    | • Expanding role for practice nurses  
• Need for lateral thinking and innovative partnerships  
• Run client-focused services balancing needs and rights  
• In March 2003, the team won a QNI innovation and creative practice award for excellence in care of refugee and asylum seekers | Not stated |
| 7       | Pfeil M, Howe A. 2004. Health care for hard to reach groups.               | Collaborative health visitor initiative and PMS service partnership | • City Reach Health Services providing primary care service for all hard to reach groups, e.g. traveller’s asylum seekers,  
• Initially staff employed on part-time contracts | Norwich, Norfolk            | Norwich Primary Care Trust                                           | • Provide a highly flexible, efficient service for vulnerable groups  
• Accessible, weekly services, e.g. in homeless shelters | Not stated |
## Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

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<th>Reported barriers/ inhibitors</th>
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</table>
| 8       | Wild S. 2005. Innovative practice – Actively managing obesity *Independent Nurse* 20 July 2005 http://www.independentnurse.co.uk/ **Journalist feature article** | Health visitor | • A lifestyle clinic for weight management, 3 days/week, 6 sessions/week; average of 15–20 patients/day; 16 times/year  
• Started January 2003 | New Southgate, West Yorkshire | • Wakefield PCT initially gave 2 years’ funding for project topped up by modernisation funds  
• At the end of project, funding reduced to 2 sessions | • Provide a new lifestyle initiative and weight management programme  
• Developing public health role for HVs  
• Develop direct GP referrals  
• Provide a dedicated level of support  
• Develop a workshop training scheme for | Not stated |
|         | Care 14: 23–26 Opinion piece | Nurse | refugees and female sex workers  
• Started May 2002 | remainder in mainstream NHS | women’s refuge, travellers sites and a specifically designed mobile unit  
• Multi-disciplinary working  
• No separation between medical and nursing agendas prevents burn-out and allows staff to widen expertise | | |
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<th>Reported barriers/ inhibitors</th>
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<tbody>
<tr>
<td>9</td>
<td>Anon. 2003. Nurse led drop in centre to help asylum seekers. <em>Primary Health Care</em> 13;3;7 <em>Journalist feature article</em></td>
<td>Specialist primary care nurse</td>
<td>• New service for asylum seekers  • Started April 2003</td>
<td>Leicester</td>
<td>Eastern Leicester PCT</td>
<td>• Help asylum seekers to receive same level of care as any other member of the community  • Provide range of information and advise on everything from language courses and paying bills, to immunisation</td>
<td>Hostility from sections of the public</td>
</tr>
<tr>
<td>10</td>
<td>Healy P. 1998. <em>Sure Thing Health Service Journal</em> 13 August: 12–13 <em>Practitioner narrative</em></td>
<td>Health visitors and community workers</td>
<td>• A model for a pre-school Sure Start project  • Start date not stated</td>
<td>Birmingham</td>
<td>• Sure Start is a national £540m initiative over 3 years  • Additional monies e.g. Midlands Police Authority</td>
<td>• Improve lives of poor families and socially disadvantaged pre-school children  • Achieve health gain in areas such as depressive illness  • Tackle infant mortality and morbidity</td>
<td>Not stated</td>
</tr>
<tr>
<td>11</td>
<td>Newcombe T, Health</td>
<td>• A family-centred,</td>
<td>Hertsmere,</td>
<td>Not stated</td>
<td>• Tackle social and</td>
<td>• Securing finance</td>
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</tr>
</thead>
</table>
| Gledstone P, 2003. Implementing group work in primary care to meet client need  
*Nursing Times* 99: 30–2  
Practitioner narrative | Visitors | public health approach among disadvantaged groups  
• Start date not stated | SW Herts | health inequality and improve health  
• Meet local community needs  
• Offer family-centred public health approach  
• Provide cost- and time-effective approach through group work  
• MD teamwork offers wider perspective on situation, facilitates enhanced services | | |
| 12 | The Walsall experience: a Summary.  
Project leaflet  
News item | Health visitors | A 12-month project ‘Baby think it over’ providing education to young people about responsibility of parenting targeting girls and boys to reduce | Walsall, West Midlands | Funded by partnership between Walsall Community Health Trust and Walsall LA  
• Health visitors raised | Not stated | Not stated |

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<th>Reported barriers/ inhibitors</th>
</tr>
</thead>
</table>
| 13      | Wrobel B. 2002. Clinic at home- a service for housebound patients with diabetes. *Journal of Community Nursing* 16: 4–6 Practitioner narrative | District nurses | • Mobile health service to annually review elderly, housebound patients with diabetes  
• Start date not stated | Barking and Havering, Essex | PCG Brentwood Community Healthcare Trust | • Address unmet patient needs  
• Improve quality of care in vulnerable groups, e.g. housebound patients with diabetes | Not stated |
| 14      | Smy J. 2004 Bringing health to the homeless. *Nursing Times* 100: 226–27 Journalist | Health visitor | • Collaborative service with local GP practice/ voluntary sector providing care and support for homeless people in 6 hostels and | Camden, North London | Camden PCT PMS funding | • Rewarding and exciting role  
• Chance to be part of innovative solutions to problems  
• Variety and challenge | Not stated |
### Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

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<th>Reported barriers/ inhibitors</th>
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<tr>
<td></td>
<td>feature article</td>
<td></td>
<td>B and Bs • Start date not stated</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Sandiford R. 2005. Caring without Prejudice. Nursing Times 101: 26–27</td>
<td>Health visitor</td>
<td>• A service development promoting awareness of travellers’ health care needs • Start date not stated</td>
<td>St Albans and Harpenden, Herts</td>
<td>• PCT funded 3-year post, initially 2 days/week • Currently post extended to 5 days per week</td>
<td>• Challenge and rewards of working with a small but disadvantaged population group • To empower and support travellers to better self-care and access to health care</td>
<td>Not stated</td>
</tr>
<tr>
<td>16</td>
<td>Rogers R. 2000 Looking after the carers Primary Health Care 10: 8–10</td>
<td>District nursing team</td>
<td>• Practice-based service unique to carers providing informal opportunity for carers to discuss health and social needs • Start date not stated</td>
<td>Belfast, N Ireland</td>
<td>• South and East Belfast Health and Social Services Trust</td>
<td>• Acknowledgement of carers social and health needs • Support carers’ mental, social and physical well-being • Make a difference to carers’ lives</td>
<td>Not stated</td>
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**Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review**

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<th>Reported barriers/inhibitors</th>
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<tbody>
<tr>
<td>17</td>
<td>Daniel K. 2001 Najam breaks new ground <em>Community Practitioner</em> 74: 256–5 <em>Journalist feature article</em></td>
<td>Health visitor</td>
<td>• Unique service effecting behavioural change among Asian men from a Pakistani community • Start date not stated</td>
<td>Huddersfield, West Yorkshire</td>
<td>Huddersfield Primary Care Group</td>
<td>• Establish methods of identifying Asian men at increased risk of coronary heart disease • Develop culture-sensitive health programme • Establish well-man group • Extend conventional approach to health visiting • Target specific vulnerable groups • Bringing own cultural knowledge, sensitivity and understanding</td>
<td>Not stated</td>
</tr>
</tbody>
</table>

*Note: There are many more examples of quasi-autonomous nurse and health visitor initiatives. For example, over the past decade the Community Practitioner journal has published articles describing at least 1–2 innovative activities per year. This equates to approximately 240 additional examples of NHS employees acting in intrapreneurial and social intrapreneurial ways.*
Table 8 Employees acting in intrapreneurial and social intrapreneurial ways: CNS-led redesigned services

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<th>Reported barriers/ inhibitors</th>
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</table>
| 1       | Anon. 1998. Awards help advance pioneering work in the community Community Practitioner 71: 82 Brief news item | Practice nurse – winner of 1997 QNI Scholarship Awards | • A nurse-led anticoagulant clinic initiative  
• Start date not stated | Bitley, County Durham | Employed by GPs supplemented by award monies (QNI £2000, and £8000 by the NHS Executive) | To treat patients at risk of stroke or heart disease locally rather than going to local hospital | Not stated |
| 2       | Davis C. 2005. Innovative Practice- Solving behavioural problems. Independent Nurse 25 July http://www.independentnurse.co.uk Journalist | School nurse – winner of Primary Care Nursing Enterprise Award 2005 | • Unique new service in UK providing children’s mental health care across 4 primary schools through effective solutions to behavioural problems in children by | Stockport, Cheshire | Stockport PCT  
• Initially PMS growth money on temp basis now half funded by PCT | • Specialist work with children from 5 years excluded from school (issues of anger, low self-esteem, soiling self-harm and ADHD).  
• Disappearance of community mental health services  
• Strong liaison/ collaborative role with | Not stated |
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<tbody>
<tr>
<td></td>
<td>feature article</td>
<td></td>
<td>primary care nurse&lt;br&gt;• Started October 2003</td>
<td></td>
<td></td>
<td>social services Youth Inclusion programme and other agencies</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Bal R. 2004.&lt;br&gt;Running the show.&lt;br&gt;Nursing Standard 19: 65&lt;br&gt;Journalist feature article</td>
<td>Cardiac Nurse Specialists</td>
<td>• Nurse-led, out of hours, mobile life-saving thrombolysis service delivered to local population&lt;br&gt;• Start date not stated&lt;br&gt; • 1st UK nurse-led spinal outreach service (hospital based but extended to monthly)</td>
<td>Fermanagh and South Tyrone, N. Ireland</td>
<td>Not stated</td>
<td>• To save a previous service from closure project – mobile coronary care unit otherwise would have been withdrawn&lt;br&gt; • Reduction in junior doctor hours&lt;br&gt; • Added dimension to nursing&lt;br&gt; • Made a reality of patient-focused care&lt;br&gt; • Serves local population&lt;br&gt; • Personal satisfaction</td>
<td>Not stated</td>
</tr>
<tr>
<td>4</td>
<td>Crouch D. 2004.&lt;br&gt;Spinal cord injury outreach&lt;br&gt;Nursing Times</td>
<td>Spinal cord injury specialist nurses – winners of NT National</td>
<td></td>
<td>Middlesbrough, Teeside</td>
<td>NHS funding</td>
<td>• Improve patient care&lt;br&gt; • Professional job satisfaction&lt;br&gt; • Continuity of care</td>
<td>Not stated</td>
</tr>
</tbody>
</table>
## Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

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<th>Reported drivers</th>
<th>Reported barriers/ inhibitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>100: 25–6</td>
<td><strong>Journalist feature article</strong></td>
<td>Award 2004</td>
<td>community clinics/visits • Start date not stated</td>
<td></td>
<td></td>
<td></td>
<td>• Empowering patients</td>
</tr>
<tr>
<td>5</td>
<td>Hoban V. 2005. Managing minor illness. <em>Nursing Times</em> 101: 20–2</td>
<td>Primary care nurses</td>
<td>Nurse-led services treating minor illnesses • Start date not stated</td>
<td>Warrington, Cheshire, Wokingham, Berkshire, and Sussex</td>
<td>Warrington, Wokingham and Sussex PCTs</td>
<td></td>
<td>• Growing area of nursing • Reclaiming a first-contact role • Opened up a career pathway • Extended/advanced nursing role</td>
</tr>
<tr>
<td>6</td>
<td>Davis C. 2005. No waiting in vein. <em>Nursing Standard</em> 20: 22–5</td>
<td>Primary care nurses</td>
<td>A collaborative primary and secondary care initiative resulting in the first primary care nurse-led centre for specialised treatment of deep vein thrombosis • Start date not stated</td>
<td>Wirral, Merseyside</td>
<td>Bebington and West Wirral PCT, Birkenhead and Wallsey PCT and Wirral Hospital NHS Trust</td>
<td></td>
<td>• Reduce number of hospital admissions • Improve A and E waiting targets • Improve patient care • Flexible patient-focused service • No reported nursing drivers</td>
</tr>
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<td>Ref No.</td>
<td>Reference</td>
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</tr>
<tr>
<td>7</td>
<td>Sands J. 2006. Nurse-led clinics halves admissions. <em>Independent Nurse</em> 13 February: 7 <strong>Brief news item</strong></td>
<td>Cardiac nurse specialist working in primary care</td>
<td>• Nurse-led heart failure clinics run from community hospitals and local DGH  • Start date not stated</td>
<td>Essex</td>
<td>Colchester and Tendring PCT</td>
<td>• Asked to set up service  • Reduce hospital admissions</td>
<td>Not stated</td>
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</table>
Table 9 Nurse consultancies in the UK: Nurses and health visitors providing their own expertise, knowledge and experience to public and private organisations

<table>
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<th>Reported barriers/ inhibitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Payne C, et al. 1997. Going it alone ... entrepreneurial nurses. <em>Nursing Standard</em> 11: 22-4&lt;br&gt;Practitioner narratives</td>
<td>Case study of Lesley Radley Independent nurse consultant</td>
<td>Nurse consultancy&lt;br&gt;LMR is a training and consultancy company offering a wide range of health care services&lt;br&gt;Works with husband on management issues&lt;br&gt;Acts as expert witness (particularly back injuries)&lt;br&gt;Started in 1989</td>
<td>Monmouth, Gwent</td>
<td>Financing not stated&lt;br&gt;Works with the NHS and with independent health care settings, RCN, GPs and social services&lt;br&gt;Works with Public and Private sector</td>
<td>Variety, interest&lt;br&gt;Exciting&lt;br&gt;Does some work with husband</td>
<td>Peaks and troughs of getting work&lt;br&gt;Time and effort to get it off the ground</td>
</tr>
<tr>
<td>2</td>
<td>Cole A. 1997. Nurses who mean business. <em>Nursing Times</em> 93: 38–9&lt;br&gt;Journalist feature article</td>
<td>Case study of Jenny Hilton Independent nurse practitioner</td>
<td>Nurse consultancy&lt;br&gt;Provides range of services including, management consultancy, teaching, expert witness, air ambulance work, work on film sets and occasional leadership cover for local</td>
<td>Yeovil, Somerset</td>
<td>Financing not stated&lt;br&gt;Works with public and private sector</td>
<td>Management reforms in 1998 were the driver to leave an NHS management role&lt;br&gt;Control of her own destiny&lt;br&gt;Personal satisfaction</td>
<td>Taking on too much work; not setting limits&lt;br&gt;Longer hours&lt;br&gt;Fewer holidays</td>
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<td>Ref No.</td>
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<td></td>
<td>community hospital</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Started in 1991</td>
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</table>
**Journalist feature article** | Case study of Mary Rolt  
Independent nurse counsellor | • Nurse counsellor and CAB/council mediator  
• Started in 1994 | Southend, Essex | Not stated | • Chance of early retirement from NHS  
• Independence  
• Personal satisfaction  
• Professional satisfaction | • Self-employment  
• No sickness benefit or holiday pay  
• Securing a clientele  
• No set income |
**Practitioner narratives** | Case study of Valerie Smith | • Independent management consultant (VMS Associates)  
• Provides: professional leadership; complex re-provision programmes for people with learning disability; development of commissioning strategy; legal expert witness; clinical risk management | Redhill, Surrey | Not stated | • Skills and expertise to undertake challenge  
• Broad range of assignments  
• Enhancement of professional work | Not stated |
### Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

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</thead>
<tbody>
<tr>
<td>5</td>
<td>Payne C, et al. 1997. Going it alone ... entrepreneurial nurses. <em>Nursing Standard</em> 11: 22–4 <strong>Practitioner narratives</strong></td>
<td>Case study of Annette Viart</td>
<td>• Started in 1994</td>
<td>Bradford-on-Avon, Bath</td>
<td>Not stated</td>
<td>• Flexibility, independence and expertise</td>
<td>• The need to market services effectively and build up clientele base</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Independent nurse consultancy (Safety Chain Specialist Nursing Consultancy)</td>
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<td></td>
<td></td>
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<td>• Provides services to NHS and independent organisations</td>
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<td></td>
<td></td>
<td>• Started in 1994</td>
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<tr>
<td>6</td>
<td>Payne C, et al. 1997. Going it alone ... entrepreneurial nurses. <em>Nursing Standard</em> 11: 22–4 <strong>Practitioner narratives</strong></td>
<td>Case study of Christine Payne</td>
<td>• Independent nurse consultancy (Copplestone Associates)</td>
<td>Rochester, Kent</td>
<td>• Income supplemented by nursing bank work, and short-term contracts with NHS units, private nursing homes and larger GP practices</td>
<td>• 1991 health reforms</td>
<td>• Reduced regular income</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Contracts with public and private sector</td>
<td></td>
<td>• Not stated</td>
<td>• Challenge and opportunity to meet personal needs</td>
<td>• Uncertainty of work</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Started in 1997</td>
<td></td>
<td></td>
<td>• Professional satisfaction</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Variety of short-term contracts</td>
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### Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

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</thead>
</table>
| 7       | Smith V. 2003. Going solo. *Nursing Management (Harrow)* 10: 8–9 **Opinion piece** **Website search** www.bomar-services.co.uk | Valerie Smith and Margaret Moody | • Managing partners of Bomar Services  
• Provides specialist advice and expertise in all areas of care home, and home-care management; main focus is to help owners improve performance and reduce operating costs through improving services and quality  
• Consultancy, advice, support and staff training, audits, verification and assessment, complaints investigation and expert reports  
• Started in 1997 | Wisbech, Cambridge | Not stated | • Belief in patients’ right to choose private or public sector health care  
• Nurses right to choose where they work  
• Professional enhancement  
• Broad range of work opportunities | Not stated |
| 8       | CPI Mediation Services Home Page **Website search** | Denise Watling | • Nurse consultancy and case management  
• Works with various client groups | Southport, Lancashire | Not stated | Not stated | Not stated |
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><a href="http://www.cpims.com">www.cpims.com</a> Practitioner narrative</td>
<td>• Developed an assessment model to quantify cost and rehabilitation efficacy • Company website hosts a forum for case managers, expert witnesses and solicitors • Started in 2002</td>
<td></td>
<td></td>
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</tbody>
</table>
British Journal of Community Nursing 9: 364 Practitioner Narrative  
Website search www.legclub.org /ellie | Ellie Lindsay | • Independent specialist nurse practitioner and clinical consultant related to leg ulcer management • Launched • Developed new evidence-based model of care and the Lindsay Leg Club charity • Started in 2002 | Ipswich, Suffolk | Not stated | • Identified a need • Empowering patients with leg problems to participate in their care, in a social environment • Professional challenge • Personal satisfaction | • Difficulty getting idea recognised • Difficulty setting up the Leg Club foundation • Hard work |
### Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

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<th>Reported barriers/ inhibitors</th>
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</thead>
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<tr>
<td>10</td>
<td>Thompson N. 2005. Making Strides. <em>The Voice: Britain’s Best Black Newspaper</em> 25 July Brief news item Website search <a href="http://www.voice-onlin">www.voice-onlin</a> e.net/content.ph p?show=5860andype</td>
<td>Norma Stride</td>
<td>Nurse consultancy and training company (Prism Partnerships Consultancy) • Provides teaching, motivational and personal development skills to nurses and health workers • Started in 2002</td>
<td>Not stated</td>
<td>Not stated</td>
<td>• Closure of college she was working at • New directions and opportunities and challenges • Family belief in a new generation of black entrepreneurs</td>
</tr>
<tr>
<td>11</td>
<td>Cole A. 1997. Nurses who mean business. <em>Nursing Times</em> 93: 38-9 Journalist</td>
<td>Case study of Roz Lloyd Davies</td>
<td>Personal injury assessor • Start date not stated</td>
<td>Not stated</td>
<td>Not stated</td>
<td>• Personal satisfaction • Fun</td>
</tr>
<tr>
<td>Ref No.</td>
<td>Reference</td>
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<tr>
<td>12</td>
<td>Hoban V. 2004. The nurse entrepreneurs. <em>Nursing Times</em> 100: 20–2 <em>Journalist feature article</em></td>
<td>Case study of Sonia Barzey</td>
<td>• Independent nurse trainer for health professionals (Ocio Solutions) • Start date not stated</td>
<td>Not stated</td>
<td>Not stated</td>
<td>• Be own boss • Not dictated to by government or organisation</td>
</tr>
<tr>
<td>13</td>
<td>Hoban V. 2004. The nurse entrepreneurs. <em>Nursing Times</em> 100: 20–2 <em>Journalist feature article</em></td>
<td>Simon Littlewood</td>
<td>• Career advisor, training and personal coaching (Wentworth Ltd) • Start date not stated</td>
<td>Not stated</td>
<td>Not stated</td>
<td>• Strong self-belief</td>
</tr>
<tr>
<td>14</td>
<td>Hoban V. 2004. The nurse entrepreneurs. <em>Nursing Times</em> 100: 20–2 <em>Journalist</em></td>
<td>Barbara Hastings-Asatourian</td>
<td>• Managing Director (Contraception Education Ltd) • Provides sex education training and workshops • Start date not stated</td>
<td>Not stated</td>
<td>Not stated</td>
<td>• Development idea • Taking a risk • Personal belief</td>
</tr>
</tbody>
</table>
## Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

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<tbody>
<tr>
<td>feature article</td>
<td>Website search</td>
<td><a href="http://www.contraception.co.uk">www.contraception.co.uk</a></td>
<td></td>
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</tbody>
</table>
• Training company aimed at expanding nurse practitioners and other advanced practice health professionals who wish to enhance their knowledge base and skills in areas that challenge professional boundaries  
• Provides workshops and master classes.  
• Start date not stated | Orpington, Kent | Not stated | Not stated | Not stated |
| Website search | | www.practitionersassosiates@yahoo.co.uk | | | | | |
| | News item | | | | | | |
| 16 | Website search | Debra Sharu | • Founder and director of | Gosport, Hants | Not stated | Not stated | Not stated |
### Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

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</table>
• Start date not stated | Not stated | Not stated | Not stated | Not stated |
**Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review**

### Table 10 Entrepreneurs: Owners (and employers)/self-employed – Indirect health care services (workforce providers)

<table>
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<th>Reported barriers/ inhibitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Naish J. Stand up and stand out Accessed 24 May 2006 <a href="http://www.justfornurses.co.uk/career/careerpath/Standupandstandout.htm">http://www.justfornurses.co.uk/career/careerpath/Standupandstandout.htm</a></td>
<td>Kate Bleasdale</td>
<td>• CEO of Match Health Care Agency for nurse returners  • Mergers with GP deputising service to form Sinclair Montrose  • 1995 establishes Medicentres  • 2001 ousted from board  • 2003 wins £2.2 million compensation for sex discrimination  • 2003 started Healthcare Locums  • 2005 buys rival Recruitment Solutions Group</td>
<td>Loughton</td>
<td>• Borrowed £10,000 from bank</td>
<td>• Spotted gap in nursing recruitment market as more hospitals used agency nurses  • Way to improve quality of patient care  • Financial reward  • Business driver  • Nurses have transferable skills</td>
<td>• Legal barriers  • Sex discrimination  • Finding continuing  • Financial backing</td>
</tr>
</tbody>
</table>

**News item**  
Nursing built my Career.  
*Nursing Standard* 20: 70–71  

**Journalist feature article**  
• CEO of Match Health Care Agency for nurse returners  
• Mergers with GP deputising service to form Sinclair Montrose  
• 1995 establishes Medicentres  
• 2001 ousted from board  
• 2003 wins £2.2 million compensation for sex discrimination  
• 2003 started Healthcare Locums  
• 2005 buys rival Recruitment Solutions Group  

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<tbody>
<tr>
<td>2</td>
<td>Hoban V. 2004. The nurse entrepreneurs. <em>Nursing Times</em> 100: 20–2 Journalist feature article</td>
<td>Case study of Michelle Patrick</td>
<td>• Started in 1987</td>
<td>Not stated</td>
<td>• HSBC loan based on 5-year business plan</td>
<td>• To make a difference • Opportunity (not stated) arose • Better lifestyle • Financial rewards</td>
<td>• 24/7 service for first 2 years only 10 hours off per week • Difficulties when second child came along</td>
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</table>
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<th>Reported drivers</th>
<th>Reported barriers/ inhibitors</th>
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<tbody>
<tr>
<td>3</td>
<td>Website search</td>
<td>Sarah Chilvers and Rory McCrea</td>
<td>• Managing directors of ChilversMcCrea Health Care Vision</td>
<td>Magdalen Laver, Essex</td>
<td></td>
<td>• Recently announced the formation of a strategic alliance with Mercury Health, part of the Tribal Group plc</td>
<td>Not stated</td>
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<td></td>
<td></td>
<td></td>
<td>• Primary care management services. 20 practices run under PMS nGMS and APMS contracts</td>
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<td>• This strategic alliance brings together NHS on the ground ‘know how’ and experience with large scale corporate muscle and finance, thus allowing</td>
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<td></td>
<td></td>
<td></td>
<td>• UK’s first corporate NHS general practice</td>
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<td></td>
<td>• Start-up costs not stated</td>
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<td></td>
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<td>• Direct clinical and management leads</td>
<td></td>
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<td></td>
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<td></td>
<td>• Plus central finance, HR and payroll functions</td>
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<td>• Staff employed by the company</td>
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<td></td>
<td></td>
<td></td>
<td>• Started in 2001</td>
<td></td>
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<td></td>
<td><a href="http://www.chilver">http://www.chilver</a> smccrea.co.uk</td>
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<td><a href="http://www.tribalgroup.co.uk/media_centre/article_detail.aspx?ID=234">http://www.tribalgroup.co.uk/media_centre/article_detail.aspx?ID=234</a></td>
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<td>Also referenced by O’Dowd A. 2005.</td>
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<tr>
<td></td>
<td>Primary care pioneers.</td>
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<td>Nursing Times</td>
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<td>101: 16–18</td>
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<td></td>
<td>Chatterjee M. 2005.</td>
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<td>Nurses appreciate benefits of privately run GP practices.</td>
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<td>Nursing Times</td>
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</table>
### Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

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<th>Reported drivers</th>
<th>Reported barriers/ inhibitors</th>
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</thead>
<tbody>
<tr>
<td>4</td>
<td><strong>Website search</strong>&lt;br&gt;Naish J.&lt;br&gt;Stand up and stand out.&lt;br&gt;Accessed 24 May 2006</td>
<td>Case study of Ann Rushworth</td>
<td>• Founder of ScotNursing: Nursing agency providing staff and training&lt;br&gt;• Start date not stated</td>
<td>Old Kilpatrick, Glasgow</td>
<td>• Initial financing not stated&lt;br&gt;• Annual turnover of £10 million</td>
<td>• Self-belief women can develop own business</td>
<td>Not stated</td>
</tr>
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<td>Ref No.</td>
<td>Reference</td>
<td>Nurse</td>
<td>The activity (date ordered)</td>
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<td><a href="http://www.justfornurses.co.uk/career/careerepath/Standardpathout.htm">http://www.justfor nurses.co.uk/career/careerepath/Standardpathout.htm</a></td>
<td>Nurse</td>
<td>[News item](<a href="http://www.justfor">http://www.justfor</a> nurses.co.uk/career/careerepath/Standardpathout.htm)</td>
<td><a href="http://www.scotnursing.com/">Website search</a></td>
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</tbody>
</table>
Table 11 Entrepreneurs: Owners (and employers)/self-employed – Indirect health care services (inventors/manufacturers)

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<tr>
<th>Ref No.</th>
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<th>Reported drivers</th>
<th>Reported inhibitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Porokhnyak M. 2005. Entrepreneur, sheep farmer, midwife. <em>The Practising Midwife</em> 8: 36–37 ltrdatacards@ aol.com <strong>Journalist feature article</strong></td>
<td>Lynette Roberts</td>
<td>• Part-time practising midwife inventor of health care product; small business selling ‘Lots to Remember’ data cards for midwives (LTR Ltd employees 8 employees) • Now expanding to other nurse groups and other professionals, such as army, police, etc. • Launched August 2002</td>
<td>• Financed printing from sale of half of husbands sheep • Product bought by individuals</td>
<td>Ashford, Kent</td>
<td>• Idea inspired from personal experience: notes/essential clinical information/ aide memoires got ruined in wash! • Clinical credibility as also working as midwife and ‘lambre’ • Professional satisfaction</td>
<td>• Daunting running a business</td>
</tr>
<tr>
<td>2</td>
<td>Hoban V. 2004. The nurse entrepreneurs. <em>Nursing Times</em></td>
<td>John Edwards</td>
<td>• Inventor of intravenous (IV) device to support IV fluids without needing full drip</td>
<td>• Financial backing from R and D Manager of New Cross Hospital, Wolverhampton</td>
<td></td>
<td>• Taking risk by developing idea • Wanting ownership of idea</td>
<td>Not stated</td>
</tr>
<tr>
<td>Ref No.</td>
<td>Reference</td>
<td>Nurse</td>
<td>The activity (date ordered)</td>
<td>Financial arrangements</td>
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<tr>
<td>100: 20–2</td>
<td>Journalist feature article</td>
<td>Nurse</td>
<td>stand (‘Hook-It’) • Product rolled out in June 2004</td>
<td>NHS trust • Product bought by NHS Purchasing and Supply Agency</td>
<td>Not stated</td>
<td>• Financial rewards</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Hill M. 2005. Lets hear it for the entrepreneur. <em>Primary Health Care</em> 15: 20–21</td>
<td>Michael Hill</td>
<td>Inventor of medical device olive oil spray (Earol®) • Launched 2005</td>
<td>Bank loan from high street bank matched by personal funding and funds from friends and family</td>
<td>Not stated</td>
<td>• Challenge of sales and marketing for an idea • Change in career direction • Nursing background</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Hoban V. 2004. The nurse entrepreneurs. <em>Nursing Times</em> 100: 20–2</td>
<td>Barbara Hastings-Asatourian – winner of British Female Inventor of the Year 2003</td>
<td>Inventor of board game to teach sex education to young people with learning difficulties • Managing director of Contraception Education Ltd</td>
<td>Not stated</td>
<td>Glossop, Derbyshire</td>
<td>• Development of an idea into a business • Improve sex education for young people with learning difficulties</td>
<td></td>
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<tr>
<td>Ref No.</td>
<td>Reference</td>
<td>Nurse</td>
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<td>5</td>
<td>Hoban V. 2004. The nurse entrepreneurs. <em>Nursing Times</em> 100: 20–2 <em>Journalist feature article</em> <em>Website search</em> <a href="http://www.medgadget.com/archives/2005/07/stabili">http://www.medgadget.com/archives/2005/07/stabili</a></td>
<td>Lisa Kagenow</td>
<td><em>Launch date not known</em></td>
<td><em>Financing not stated</em></td>
<td>Not stated</td>
<td><em>Part of PhD research at Oxford University</em> <em>Identified problem and designed a solution</em> <em>Desire to make nursing easier</em> <em>Improve patient care</em></td>
<td>Not stated</td>
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</tbody>
</table>
**Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review**

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### Table 12  Entrepreneurs: Owners (and employers)/self-employed – Providers of mainstream NHS health services through direct contract with NHS

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<tr>
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<th>Reported drivers</th>
<th>Reported barriers/ inhibitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Daniel K. 2000. Moving on. Community Practitioner 73: 830–1  Journalist feature article Cohen P. 1998. Breaking down the barriers. Community Practitioner 71: 93 News item</td>
<td>Mary Low and Celia Suppiah</td>
<td>• Thurrock Community Mothers Programme: partnership working  • Operates under PMS contract  • Developed from PMS pilot in 1998</td>
<td>Grays, Essex</td>
<td>• QNI funding enabled service to build on fragmented existing services</td>
<td>• Tackle health inequalities  • Personal experience, understanding and credibility among homeless and travellers  • Advocate of the PMS initiative  • Personal and professional job satisfaction  • Multi-disciplinary partnership working</td>
<td>Not stated</td>
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</tbody>
</table>

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### Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

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<tr>
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<th>Reported drivers</th>
<th>Reported barriers/inhibitors</th>
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</thead>
<tbody>
<tr>
<td>2</td>
<td>Payne D. 1998. <em>Working up to a new partnership in an old practice.</em> <em>Nursing Times</em> 94 (1) <strong>Journalist feature article</strong></td>
<td>Lesley Hargreaves</td>
<td>• Nurse clinician successfully bid to run a single GP practice list in partnership with GP • Started in 1998</td>
<td>Ormskirk, South Lancashire</td>
<td>• Independent contractors to NHS</td>
<td>• To develop a nurse-led system of primary care extending nursing role to focus on improving health promotion, chronic disease management referrals to secondary care • Extended role as nurse clinician</td>
<td>Patients fear of a two-tier system of health</td>
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<tr>
<td>Ref No.</td>
<td>Reference</td>
<td>Nurse</td>
<td>The activity (date ordered)</td>
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</table>
**Journalist feature article**  
Editorial 2005 primary care contracting: How to set up and run your own practice  
*Independent Nurse* 24 January | Catherine Baraniak – received an OBE for services to primary care in 2003 | • Independent nurse contractor operating new single-handed nurse-led primary care practice  
• Part of the first wave of nurse-led pilot PMS employing 25 staff including 2 GPs  
• Nurses perform the majority (65%) of consultations. GP remains clinically | Derby, Derbyshire | Self-employed | • Shift in powerbase from GPs to wider team; patients to see most appropriate provider  
• Patients involved in service design  
• Benefits of self-employment, include better pay and greater job satisfaction | • See King’s Fund report findings  
• PMS contractors can be isolating  
• No safety net for nurses  
• Doubt that nurse-led PMS would work in mainstream population |

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### Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

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<td><strong>Journalist feature article</strong></td>
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<td><a href="http://www.independentnurse.co.uk/professional/index.cfm?fuseaction=ArticleViewand">www.independentnurse.co.uk/professional/index.cfm?fuseaction=ArticleViewand</a></td>
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<td>Crawford M. 1998.</td>
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<td></td>
<td>Nurses lead the way.</td>
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<td></td>
<td><em>Practice Nurse</em></td>
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<td><strong>News item</strong></td>
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<td>A normal community.</td>
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<td><em>Primary Health Care</em></td>
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<td>11: 14–5</td>
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<td><strong>Practitioner narrative</strong></td>
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- operates under ‘PMS only’ contract  
- Started in August 1998
### Table: Ref No. Reference Nurse The activity (date ordered) Geographic location Financial arrangements Reported drivers Reported barriers/inhibitors

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<th>Ref No.</th>
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<td>A pioneering role for nurses.</td>
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<td><em>Primary Health Care</em> 11: 5</td>
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<td></td>
<td>Breaking down the barriers.</td>
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<td><em>Community Practitioner</em> 71: 93</td>
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<td><strong>Opinion piece</strong></td>
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<td></td>
<td>Nurse-led primary care: Learning from Pilot sites. p12.</td>
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<td>Report analyses data gathered</td>
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### Ref No. 4


Report analyses data gathered from 9 nurse-led pilot sites through 2 focus groups

**King’s Fund report**

Crawford M. 1998. Nurses lead the

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<tr>
<th>Nurse</th>
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<th>Reported barriers/ inhibitors</th>
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</thead>
</table>
| Theresa Kerney and Mary Low | Nurse practitioner and health visitor operating a PMS nurse-led pilot for travellers and homeless families and outreach services  
Operates under ‘PMS plus’ contract; plus includes midwifery and child development  
Started in October 1998 | Grays, Essex | Contracted to South Essex Mental Health and Community Trust | Target vulnerable patient groups  
Redesign services to become more patient focused  
Maximise nurse and doctor competencies | Also see King’s Fund report findings  
Struggle of implementing pilot site  
New model of service  
Insufficient flexibility  
Regulatory obstacles  
Primary-secondary care inter-professional tension/recognition/equality/cooperation  
Referral acceptances  
Pressure from being a pioneer/role model  
Suspicion/scepticisms/ |
**Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review**

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<tbody>
<tr>
<td>5</td>
<td>Chapple A. 2000. Two years’ experience of a nurse-led pilot scheme: patients’ perceptions. Primary Health Care 10: 14–7 Research A research study that investigated patients perceptions of a nurse-led, personal medical service.</td>
<td>Lance Gardner</td>
<td>• Independent nurse contractor: Part of the first wave of pilot PMS service schemes • Nurse-led primary care service; took over a vacant single-handed GP practice • One of three projects in Manchester that aimed to develop a new arrangement involving the community in the work and</td>
<td>Salford, Manchester</td>
<td>Independent contractor to Salford NHS PCT</td>
<td>• PMS described as the most radical initiative in primary care so far • Success relates to commitment of skilled, experienced individuals • Nurse-led PMS pilots represent a vanguard of new and extended roles for nurses in primary care</td>
<td>Complicated administration and management issues such as: • Certification: nurses cannot sign death or sickness certificates and, since Mental Health Act 1984, nurses cannot section patients • Prescribing: Nurses restricted in prescribing autonomy at the time of the pilot • Grant allocation: NPact legislation did not allow health authorities to allocate</td>
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<tbody>
<tr>
<td>Moore A. 2002.</td>
<td>PMS mood swings.</td>
<td>Nurse</td>
<td>governance of statutory agencies</td>
<td></td>
<td></td>
<td></td>
<td>improvement grants to nurses; services could be in substandard accommodation</td>
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<td></td>
<td>Health Service Journal 112: 12–14</td>
<td></td>
<td>• Adapted the ‘school governor model’ to create a governing body of patients, city councillors, PCG members and 2 PMS pilot staff members</td>
<td></td>
<td></td>
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<td>• Premise that nurse-led PMS are for the most vulnerable and needy, deserving type of care best provided by nurses, but in reality relies on partnership between GP and nurses</td>
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<td>data gathered from 9 nurse-led pilot sites through 2 focus groups</td>
<td>Nurse</td>
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<td>Opinion piece</td>
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<tbody>
<tr>
<td>6</td>
<td>Lewis R, et al. 2001. Nurse-led primary care: Learning from Pilot sites. <strong>King’s Fund report</strong> Report on research data</td>
<td>Summary evaluation of activities of 9 nurses at:  - Acorns  - Appleton primary care  - Arch day centre  - Daruzzaman  - Edith Cavell  - Meadowfields  - Morley Street  - Spitalfields  - Valley park</td>
<td>• First nurse-led PMS activities, 5 managed by community NHS trusts, 2 managed by existing GP practices and 2 managed by nurses  • Started in April 1998 – Dec 1999</td>
<td>UK wide</td>
<td>NHS Trust</td>
<td>• To maximise nursing skills  • Allow nurse leadership within PHC team  • Break down professional boundaries between medical and nursing roles  • Provide new model of care nurses  • Improve access to services  • Empower patients  • Develop partnerships with other agencies and community groups</td>
<td>• Struggle of implementing pilot site  • New model of service  • Insufficient flexibility  • Welfare and NHS Regulatory obstacles  • Restricted prescribing facility  • Primary secondary care interprofessional tension/recognition/equality/cooperation  • Referral acceptances  • Pressure from being a pioneer/role model  • Suspicion/scepticism and some hostility towards model of care, particularly to mainstream rather disadvantaged population  • Limited support from</td>
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# Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

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</tr>
</thead>
</table>
| 7       | O'Dowd A. 2005. Primary care pioneers. *Nursing Times* 101: 16–18 | Kate Cernik | • Lead nurse and senior partner in 3-way partnership of lead nurse, practice manager and GP  
• Part of the first wave nurse-led pilot PMS in new practice in affluent part of Warrington  
• Operates under ‘PMS plus’ contract: plus community nursing services  
• Started in August 1999 | Warrington, Cheshire | Independent contractor to NHS | • To offer holistic patient-focused services  
• Develop primary care opportunities for nurse entrepreneurs increasing scope for nurse partners; breaking down professional boundaries  
• Offer good ‘value’ | professional bodies  
• See also King’s Fund report findings  
• Confidence  
• Communication with GPs |

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</table>
• Nurse is a full partner, has partner’s vote, caseload, own practice room and parking space | Doncaster, | • Self-employed; receives percentage of the practice partnership  
• Independent contractor to NHS | • Difficulty in recruitment of GP enabled nurse to become a partner | • Professional tensions and jealousies  
• Some distrust locally of nurse prescribing |

NB: has also set up a small training company with a GP to present workshops for nurses interested in contracting opportunities.
### Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Reference</th>
<th>Nurse</th>
<th>The activity (date ordered)</th>
<th>Geographic location</th>
<th>Financial arrangements</th>
<th>Reported drivers</th>
<th>Reported barriers/ inhibitors</th>
</tr>
</thead>
</table>
**Journalist feature article** | Jane Macpherson | • Nurse-led GP practice in which a full practice partner of 4.5 full-time equivalent (FTE) GPs and 1 FTE nurse partner managing total of 12 full-time staff including 4 RGNs and 1 nursing assistant  
• Operating under a nGMS contract  
• Started in Jan 2001 | Lanarkshire Scotland | • Independent contractor to NHS | • Start of fundholding prompted expanding role beyond clinical activities and move into strategic and managerial functions  
• Changing cultures  
• Clinical patient-focused nurse-led approach | Not stated |
### Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

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<th>Ref No.</th>
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<th>Reported barriers/inhibitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Houghton M. 2002.</td>
<td>Joanne Davidson, Julie Burford and Yvette Townsend</td>
<td>• Pioneering primary health care practice first nurse-led PMS pilot scheme in West Midlands&lt;br&gt;• Operates under a 3-way equal partnership; employs the GP whose practice has been bought (GP has since retired and has not been replaced yet because of area) and 12 people&lt;br&gt;• The practice houses Citizen’s Advice Bureau, alcohol advisory services, counselling services, access to internet, health</td>
<td>Tipton, West Midlands</td>
<td>• £250,000 raised from bank to buy GP practice&lt;br&gt;• Operate as Independent contractors to NHS</td>
<td>• Opens up new career structure&lt;br&gt;• Allows creative ideas to meet local need&lt;br&gt;• ‘Nurse-led culture’ better for patient care&lt;br&gt;• More time and continuity of care&lt;br&gt;• Provides new services within same resources&lt;br&gt;• Teamwork success&lt;br&gt;• Being an entrepreneur and risk-taker&lt;br&gt;• Confidence&lt;br&gt;• Persistence</td>
<td>• Legislation: Currently no parity with doctors over prescribing&lt;br&gt;• Attracting GP to work in the practice</td>
</tr>
</tbody>
</table>
### Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

<table>
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<tr>
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<th>Reported drivers</th>
<th>Reported barriers/ inhibitors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>information GP and nurse practitioner services</td>
<td>Leigh, Lancashire</td>
<td>Independent contractor to NHS</td>
<td>Pay not seen as always a priority</td>
<td>Challenge to status quo for nurses and doctors</td>
</tr>
</tbody>
</table>
| 11      | O’Dowd A. 2005. Primary Care Pioneers  
*Nursing Times* 101: 16–18  
Journalist feature article  
*Nursing Standard* 19: 12–13  
Journalist feature article | Delia Clarke | • Nurse partner in two-way partnership with practice manager  
• Operates under PMS contract  
• Started in 2002 | • Independent contractor to NHS | • Pay not seen as always a priority  
• Emphasis on quality of care  
• Greater job satisfaction  
• Poor GP recruitment provides opportunity for professional career development | • There is still lack understanding of about PCTs in relation to pension (non-GP providers in GMS and PMS eligible for NHS pensions)  
• Indemnity insurance not available through RCN; had to get it from a medical protection association |
### Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Reference</th>
<th>Nurse</th>
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<th>Reported barriers/ inhibitors</th>
</tr>
</thead>
</table>
- Operates under APMS contract  
- Started in April 2005 | Hanwell, West London | - Investment by ECT Group a local social enterprise group  
- Not for profit enterprise  
- Independent contractors to NHS | - Challenge to run own practice  
- Opportunity for nurse-led development  
- Patients registered with practice not GP  
- GPs now have longer appointment times  
- Nurse practitioners manage long-term conditions and same-day appointments | Not stated |
<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Reference</th>
<th>Nurse</th>
<th>The activity (date ordered)</th>
<th>Geographic location</th>
<th>Financial arrangements</th>
<th>Reported drivers</th>
<th>Reported barriers/ inhibitors</th>
</tr>
</thead>
</table>
| 13      | O’Dowd A. 2005. Primary care pioneers. *Nursing Times* 101: 16–18 | Helen Ramsey | • The only full and equal nurse partner of 7 partners  
• Operates under nGMS contract  
• Started April 2005 | Gateshead | • Independent contractor to NHS | • Partnership gives official role involved in decision-making  
•Permits voting rights on the board | • Challenge to status quo from nurses and doctors  
• PCTs still lack understanding of pension (non-GP providers in GMS and PMS eligible for NHS pensions) issues and insurance  
• Indemnity insurance not available through RCN only through a |
### Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Reference</th>
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<th>Financial arrangements</th>
<th>Reported drivers</th>
<th>Reported barriers/ inhibitors</th>
</tr>
</thead>
</table>
| 14      | Crumbie A. 2006 Nurse partnership for nurse practitioner. *Primary Health Care* 16: 14–16 *Personal Narrative* | Alison Crumbie | • Profit-sharing partner  
  • Operates under nGMS contract  
  • Started April 2005 | Windemere, Cumbria | • Independent contractor to NHS | • New responsibilities  
  • Professional challenge and excitement  
  • Personal and financial commitment | • Greater level of liability  
  • Indemnity insurance from RCN |
| 15      | Pritchard J. 2005. Providing nursing services under a SPMS contract. *Independent Nurse* October 3: 6–7 | Jo Pritchard and Tricia McGregor | • Primary care directors of nurse led limited company Central Surrey Healthcare providing community and school nursing and | East Elmbridge and Mid Surrey PCT | • Limited not for profit company  
  • £27 million contract agreed by PCT  
  • Each | • Organisational stability, culture shift and responsiveness  
  • SPMS contract is seen as future proof and flexible  
  • Gives control over how and who delivers | Not stated |
## Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review

<table>
<thead>
<tr>
<th>Ref No.</th>
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<th>Reported drivers</th>
<th>Reported barriers/ inhibitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opinion piece</td>
<td>Anon. 2005.</td>
<td>Nurse</td>
<td>therapy services</td>
<td></td>
<td>employee will have one share in the company retaining NHS conditions of work, including NHS pension</td>
<td></td>
<td>services</td>
</tr>
<tr>
<td></td>
<td>Nurses win contract to provide services</td>
<td></td>
<td></td>
<td></td>
<td>Will operate under SPMS contract</td>
<td></td>
<td>Allows NPs to think innovatively,</td>
</tr>
<tr>
<td></td>
<td>Independent Nurse 21 Nov: 3</td>
<td>Content</td>
<td>Approval granted April 2006</td>
<td></td>
<td></td>
<td></td>
<td>Ties in with government aims for PCTs to commission services from outside contractors rather than providing services themselves</td>
</tr>
<tr>
<td>Brief news item</td>
<td>Anon. 2005.</td>
<td>Nurse</td>
<td>therapy services</td>
<td></td>
<td>employee will have one share in the company retaining NHS conditions of work, including NHS pension</td>
<td></td>
<td>services</td>
</tr>
<tr>
<td></td>
<td>Nurse-owned company wins PCT contracts</td>
<td></td>
<td></td>
<td></td>
<td>Will operate under SPMS contract</td>
<td></td>
<td>Allows NPs to think innovatively,</td>
</tr>
<tr>
<td></td>
<td>Nursing Standard Nov 23: 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ties in with government aims for PCTs to commission services from outside contractors rather than providing services themselves</td>
</tr>
<tr>
<td>Brief news item</td>
<td>Bower, E. 2006.</td>
<td>Nurse</td>
<td>therapy services</td>
<td></td>
<td>employee will have one share in the company retaining NHS conditions of work, including NHS pension</td>
<td></td>
<td>services</td>
</tr>
<tr>
<td></td>
<td>Social enterprises need support right now.</td>
<td></td>
<td></td>
<td></td>
<td>Will operate under SPMS contract</td>
<td></td>
<td>Allows NPs to think innovatively,</td>
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<tr>
<td></td>
<td>Independent Nurse 20 February: 11</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Ties in with government aims for PCTs to commission services from outside contractors rather than providing services themselves</td>
</tr>
<tr>
<td>Ref No.</td>
<td>Reference</td>
<td>Nurse</td>
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<td>Reported drivers</td>
<td>Reported barriers/ inhibitors</td>
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<tr>
<td>16</td>
<td>O’Dowd A. 200. Primary care pioneers <em>Nurses Times</em> 101: 16–18</td>
<td>Linda Aldous</td>
<td>• Joined as practice nurse partner in 1999 under old GMS contract Now 8 partners: 5 GP partners, nurse partner, manager partner and honorary partner • Employs staff of 27 • Operates under a PMS contract • Start date not stated</td>
<td>Bromley by Bow, East London</td>
<td>• Self-employed, contracting to local PCT</td>
<td>• Team work, negotiation skills • Energy and vision • Voice for nurses through decision-making process • Patient advocacy</td>
<td>Not stated</td>
</tr>
<tr>
<td>Ref No.</td>
<td>Reference</td>
<td>Nurse</td>
<td>The activity (date ordered)</td>
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<td></td>
<td>(NB: NatPact program closed on 31 Mar 2005)</td>
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<td>Practitioner narratives</td>
</tr>
</tbody>
</table>

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Table 13 Entrepreneurs: Owners (and employers)/self-employed – NMHV services offered directly to clients

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Reference</th>
<th>Nurse</th>
<th>The activity (date ordered)</th>
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<th>Reported drivers</th>
<th>Reported barriers/ inhibitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Cole A. 1997. Nurses who mean business. <em>Nursing Times</em> 93: 38–9</td>
<td>Mary Rolt Registered Nurse</td>
<td>• Independent counsellor • Undertakes a range of jobs: counselling, consultancy, teaching, Citizen’s advice Bureau work and mediator for local council • Started in 1994</td>
<td>Not stated</td>
<td>Not stated</td>
<td>• Opportunity for early retirement • Greater independence</td>
<td>Not stated</td>
</tr>
<tr>
<td>2</td>
<td>Munro R. 1999. The Battler of Hastings... Steve Clifford. Community Mental Health Nurse. <em>Nursing Times</em> Jan 27–Feb 4: 32–3</td>
<td>Steve Clifford Community Psychiatric Nurse</td>
<td>• Independent community psychiatric nurse practitioner working from a GP practice • Also provides staff training, consultation, counselling and</td>
<td>Rye, East Sussex</td>
<td>Not stated</td>
<td>• Vision and faith • New opportunity • Ability to negotiate contracts • Job flexibility and immediacy of contact • Personal and Professional accountability</td>
<td>• Being able to negotiate contracts • Becoming more flexible in your work • Daunting prospect of self-employment</td>
</tr>
</tbody>
</table>
## Ref No. Reference Nurse The activity (date ordered) Geographic location Financial arrangements Reported drivers Reported barriers/inhibitors

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Reference</th>
<th>Nurse</th>
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<th>Reported barriers/inhibitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Rigby M. 2000. They are. Are you?... the pros and cons of being an independent practitioner. <em>Nursing Times</em> 20–26: 32–3</td>
<td>Deborah Rigby Registered Nurse</td>
<td>Supervision • Employs 1 part-time therapy assistant • Started in 1995</td>
<td>Not stated</td>
<td>Services bought by individuals</td>
<td>• Autonomy • Fortnightly supervision gives maintenance of peer contact • Enhancing professional status</td>
<td>• Personal indemnity insurance • Erratic referrals • Overhead costs</td>
</tr>
<tr>
<td>4</td>
<td>Rigby M. 2000. They are. Are you?... the pros and cons of being an independent practitioner.</td>
<td>Mary Dolman Registered Nurse</td>
<td>Independent CNS providing stoma and continence care • Start date not stated</td>
<td>Ascot, Berkshire</td>
<td>Services bought by individuals • Financing not stated</td>
<td>• Self-belief in skills and clinical expertise</td>
<td>• Not stated</td>
</tr>
<tr>
<td>Ref No.</td>
<td>Reference</td>
<td>Nurse</td>
<td>The activity (date ordered)</td>
<td>Geographic location</td>
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<td>Reported drivers</td>
<td>Reported barriers/ inhibitors</td>
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<tr>
<td>1</td>
<td>Nursing Times 20–26: 32–3 Journalist feature article</td>
<td>Nurse</td>
<td></td>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Funding direct from clients</td>
<td>Greater job satisfaction</td>
<td>Irregular income</td>
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<td></td>
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<td></td>
<td>Compulsion to help people</td>
<td>Reduced income</td>
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<td></td>
<td>Financial rewards</td>
<td>Professional isolation</td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td>Reasons for leaving NHS: disillusionment, job dissatisfaction, lack of continuity, stress</td>
<td>Lack of business acumen</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>Job to do as got older</td>
<td>Business-related stress factors</td>
</tr>
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<td></td>
<td>To practice a holistic form of care</td>
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<td></td>
<td>Belief in efficacy of complementary medicine</td>
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<td></td>
<td></td>
<td>Gap in NHS service provision</td>
<td></td>
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<tr>
<td>Ref No.</td>
<td>Reference</td>
<td>Nurse</td>
<td>The activity (date ordered)</td>
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</table>
### Table 15 Entrepreneurs: Owners (and employers)/self-employed – Other health related services and accommodation by nurses proprietors

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Reference</th>
<th>Nurse</th>
<th>The activity (date ordered)</th>
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<th>Financial arrangements</th>
<th>Reported drivers</th>
<th>Reported barriers/inhibitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Website search</td>
<td>Jane Taylor</td>
<td>• Managing director of Positive Lifestyles Health Ltd</td>
<td>West Cardiff, Wales</td>
<td>• Start up costs not stated</td>
<td>Not stated</td>
<td>Not stated</td>
</tr>
</tbody>
</table>
### Ref No. | Reference | Nurse | The activity (date ordered) | Geographic location | Financial arrangements | Reported drivers | Reported barriers/inhibitors
---|---|---|---|---|---|---|---
| | | | staff  
• Started in 2001 | | | |
### Table 16 Research studies on nurse entrepreneurs

<table>
<thead>
<tr>
<th>Reference</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Empirical work</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Background:</strong> During the 1980s many nurses left the NHS to own and run private residential care homes for the elderly. The withdrawal of guaranteed state funding and introduction of social care markets have had negative impacts on many of these care homes. This study considers the actions and attitudes of former nurse proprietors.</td>
</tr>
<tr>
<td><strong>Aims:</strong> To investigate a gap in research about the relationship between nurses, nursing and residential homes and to provide evidence relating to the experiences of former NHS nurses as independent proprietors of nursing homes in light of significant policy change through the 1980s and 1990s.</td>
</tr>
<tr>
<td><strong>Method:</strong> Three-stage survey conducted between 1994 and 1997 of 150 nursing home owners in South Devon. Semi-structured interviews and follow-up questionnaires undertaken 1–3 years following baseline data collection. Analysis of 30/150 nurses (28.6%).</td>
</tr>
<tr>
<td><strong>Findings:</strong> A range of reasons for home ownership including: being your own boss, perceived benefits of greater responsibility, career control, be in charge, take risks, be a success; income generation was a lesser motivator. While small business in the private sector may have seemed attractive to nurses in the 1980s, any move into private sector is associated with risk. Social policy conditions may change, with consequences for businesses and business owners. Key negative factors include: financial insecurity, stress, inexperience and lack of management skills.</td>
</tr>
</tbody>
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<tr>
<th>Country</th>
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<tbody>
<tr>
<td>UK</td>
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</table>

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<table>
<thead>
<tr>
<th>Reference</th>
<th><strong>Empirical work</strong></th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses who left the British NHS for private complementary medical practice: why did they leave? Would they return? <em>Journal of Advanced Nursing</em> 41: 403–15 (Database ref)</td>
<td>Businesses in complementary therapy, an area that has undergone rapid expansion in recent years. <strong>Aims:</strong> To investigate the motivations and experiences of nurses who have set up services providing complementary medicine. Focusing on the significance of nurses pursuing careers in complementary medicine moving away from the NHS. To put into context evidence associated with nurse recruitment and retention in relation to training needs, stressors of nursing (such as limited resources, changing/increasing workloads, changing roles) job satisfaction and alternative career options in private practice. <strong>Method:</strong> Qualitative study using a combined questionnaire (n=63) and semi-structured interview (n=11) approach. <strong>Findings:</strong> Greater synergy between orthodox and complementary medicine may be one way of addressing shortages of nursing labour while meeting evolving consumer health care. Many practising complementary therapists are registered nurses who may be willing to re-enter the formal health service. <strong>Key motivating factors:</strong> Having the choice to return to caring nursing-type roles, greater work-pattern flexibility and autonomy, being able to practise in a better way, positive experiences of complementary medicine compared to ordinary medicine/restrictions of medical models. Recognition of a gap in service provision. Interest in alternative treatment methodologies. Personal and professional satisfaction in helping to empower patients. <strong>Key barriers:</strong> Financial insecurity, irregularity of work, reduced income, lack of business skills (associated stress), isolation, loss of sick or maternity benefit.</td>
<td></td>
</tr>
</tbody>
</table>
Reference | Empirical work | Country
--- | --- | ---

**Background:** Evaluation of the nine first-wave, nurse-led PMS pilots in primary care that went live in 1998/1999; 8/9 pilots newly established providing services where none were before. Five were in community NHS trusts, 2 managed by existing GP practices and 2 managed by nurses acting as independent contractors. Six out of 9 were designed to serve specific targeted populations or increase access to areas under-served by doctors. Most common population groups were the homeless, refugees and asylum seekers.

**Aims:** To understand the experiences and perceptions of a group of nurse pioneers as they sought to implement an ambitious personal and professional agenda and to examine nature and characteristics, value systems and relationships of the nurses with other professional and hospital services.

**Methodology:** Evaluation of the progress made in 2 years since inception through two focus groups of nurse leads.

**Findings:** Nurse-led care describes culture of professional equity and patient-focused services. Transcends any model of nurse leadership. Generally, extended nurse roles are successful, cost-effective and achieve high patient satisfaction.

Model of enhanced nursing roles not without controversy, with resistance and blockages identified in some quarters. Local controversy reported among doctors in relation to nurses challenging traditional practices that has raised ethical debate about potential of a two-tier system. Among the positive aspects is the development of new relationships between nurse and doctor and across health care boundaries. Among negative aspects are bureaucratic and legislative issues, such as prescribing, certification, poor management support. A new infrastructure and professional nursing body
**Nurse, Midwife and Health Visitor Entrepreneurs: A scoping review**

<table>
<thead>
<tr>
<th>Reference</th>
<th>Empirical work</th>
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</thead>
<tbody>
<tr>
<td><strong>4. Chapple A. 2000.</strong>&lt;br&gt;Two years’ experience of a nurse led pilot scheme: Patients’ perceptions. Primary Health Care 10: 14–17 (Database ref)</td>
<td><strong>Background:</strong> Working relationships between nurses and doctors in primary care undergoing rapid change and nurses are taking on new roles. Two nurse-led pilot schemes operating for 2 years are good examples of these changing roles and relationships.&lt;br&gt;<strong>Aims:</strong> To evaluate whether nurse-led PMS provide improved services to disadvantaged groups and to discover patients’ perceptions of a nurse-led service.&lt;br&gt;<strong>Methodology:</strong> Qualitative interview study of 28 patients.&lt;br&gt;<strong>Findings:</strong> Suggest patients support nurse-led initiatives. Nurses were as knowledgeable as the doctors and they had real choice over who they consulted with. Nurse-led practices provide a viable option, particularly in areas where GPs are hard to recruit or where GP turnover is high.</td>
<td><strong>UK</strong></td>
</tr>
<tr>
<td><strong>5. Roggenkamp SD, White KR. 1998.</strong>&lt;br&gt;Four Nurse Entrepreneurs: What motivated them to start their own businesses. Health Care Management Review 23: 67–75. (Database ref)</td>
<td><strong>Background:</strong> In an environment of change, innovators or entrepreneurs emerge to develop new methods and processes of delivering health care in a way that lowers the overall costs of care while improving outcomes.&lt;br&gt;<strong>Aims:</strong> To investigate the factors that motivate nurse entrepreneurs, as well as the characteristics of nurse entrepreneurs and their business ventures. The rationale for health care managers to capitalise on nurse entrepreneurship is discussed as an effective method of strategic adaptation.&lt;br&gt;<strong>Methodology:</strong> Qualitative study of 4 nurse entrepreneurs (3 different types</td>
<td><strong>USA</strong></td>
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### Background:
This study builds upon the conceptualisation of part of the entrepreneurial process that is frequently labelled ‘entrepreneurial attitude orientation’, focusing on entrepreneurial attitudes rather than personal traits.

### Aims:
To investigate the usefulness of two new exploratory recognition scales expanded from the original Exploratory Opportunity Attitude scale (EOA) to measure attitude to risk (Entrepreneurial Risk Willingness) and

### Findings:
Three emerging patterns identified. Instigating factors, business factors (enablers, disablers, characteristics of the business), and personal factors (characteristics of the nurse entrepreneur).

Personal motivating factors take form of reward, financial, freedom and flexibility, expert status and leaving a professional legacy.

‘Instigating factors’ included “nurses’ love of particular field of nursing” and was a prevailing theme in how business operated, response to the challenge and evaluation of the rewards of owning own business, risk taking, assertiveness, and strong sense of leadership.

Barriers within ‘business factor’ include: lack of business skills/business deficiencies and perception of poor preparation to run business venture.
Reference | Empirical work | Country
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Grey ref | recognition of opportunity (Entrepreneurial Opportunity Recognition) in order to test contextual and behavioural characteristics of nurse entrepreneur activity. |  
**Methodology:** Questionnaire survey of 515 nurses randomly selected from nurse entrepreneurs registered with the National Nurses in Business Association (NNBA).  
**Findings:** Of the 139 nurse entrepreneurs who responded, 11 were excluded because of missing data. Data were compared for the 99 nurses identified as self-employed and the 29 in traditional employee roles. The majority were female (88%), 89% were Caucasian and 60% had undertaken at least one business course. The EOR scale is a useful tool to discriminate between nurse entrepreneurs and non-nurse entrepreneurs and can help classify nurse entrepreneur characteristics in terms of achievement, perceived control, innovation and self-esteem and entrepreneurial opportunity recognition traits. Nurse entrepreneurs in independent practice are predominantly more personal achievement orientated, desiring to win, achieve and be successful, measuring themselves by level of success. Nurse entrepreneurs in collaborative practice are predominantly 'affiliators', enjoying team work environment, teaching and working with others, measuring themselves by their social care giving, and function as contributors to lives of patients and colleagues. Future research should focus on exploring the multi-dimensional view of the entrepreneurial process. |  
Decisions behind career choice for nurse practitioners: independent versus collaborative practice and motivational- | Background: In response to changing health care needs and trends, extended and advanced nursing practice roles developed and nurse practitioners are now taking an active role in defining and establishing their | USA |
**Aims:** To examine personality information and motivational needs behaviours based around 7 open-ended questions that may underlie practice choices for advanced practice among independent primary care nurse practitioners.

**Methodology:** Interviews conducted with independent nurse practitioners (n= unspecified; recruited from 3 US states [not specified]) and nurses working in a collaborative practice (n=unspecified). Selection criteria not specified.

**Findings:** Independent nurse practitioners are more business focused, achievement orientated and driven towards success, presenting patient care as a secondary concern compared to nurse practitioners working within collaborative practices. Independent nurse practitioners value the freedom and flexibility of independent practice and in recognition of the challenges and struggles of running their own business, remuneration issues and on-call hours develop strong supportive networks. Conversely, collaborative nurse practitioners emphasise the importance of an interactive, team approach to work practice and the benefits of ensuring a family, social and work life balance. Collaborative nurse practitioners did not wish to work alone or take the risk of becoming independent.

**Reference**


**Empirical work**

career pathways as independent or collaborative practitioners. However little is written about how nurse practitioners make career choices.

**Background:** Changes in the US health care industry have created diverse opportunities for clinical nurse specialist (CNS) entrepreneurs. This literature review only explores the types, advantages, barriers and implications of CNS entrepreneurs.

**Methodology:** Search of CINAHL® and Ovid (dates not specified).
### Findings:
383 articles identified pertaining to nurse entrepreneurs, skill and attributes. Various types of CNS entrepreneurs identified in diverse specialities. Three main types of business structure described including: sole proprietorship, general partnership and corporation. Sub-roles of the attributes and skills of a CNS reflect the roles of CNS entrepreneurs such as leader, consultant, collaborator, advocate negotiator and expert in marketing and product presentation. Major characteristics include, visionary, decision-maker, problem-solver, risk-taker, self-starter and good communicator. Comparison of CNS entrepreneur is made to Benner's, Novice to Expert Model.

**Key advantages include:** Flexibility and freedom to focus on personal interests, quality and variety of work.

**Disadvantages include:** Higher cost of malpractice insurance, lack of hospital privileges, professional scepticism, start-up costs, business acumen.

### Background:
The role of nurse practitioners developed in response to the need for advanced practice nursing skills in primary care settings, specifically in pediatrics, and has been continually evolving. Shifts in health care have seen advanced practice oncology nursing services moving from the acute-care sector across a variety of health care settings including ambulatory, private practice, health management organization, community and occupational and homecare settings. This literature review only explores the emerging role of the oncology nurse practitioners as partner in collaborative private practice.

**Methodology:** Search of articles, book sections and personal experience
An Australian study. Findings reported through two different papers


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**Findings:** The emerging oncology nurse practitioner role can effectively meet both medical and nursing needs of patients. A collaborative model can achieve better patient outcomes within the private practice setting. Major obstacles in the implementation of oncology nurse practitioner roles in private practice include: developing a supportive, collaborative relationship with oncology physicians in order to achieve shared care authority, limited/inconsistent prescriptive authority across the states, insurance reimbursement problems and professional role recognition.

**Background:** The changing Australian health care system is providing increasing opportunities for nurses to work directly with clients in private practice settings. The concept of entrepreneurship as a process recognises opportunity and open endeavour in a competitive health care market, addressing issues of economics, service access and development of suitable health services. Little is known about private practice nursing as an area of advanced practice. As more nurses are taking the option to develop private practice the experiences of and influences on nurses currently in private practice might be a useful guide to the pitfalls and difficulties that might be encountered.

**Aims:** To increase understanding of private practice nursing and generate greater insight into its efforts to improve and maintain quality nursing services within the Australian health care system, this paper aimed to elicit and assess consensus on the reasons for nurses going into business and the experiences they encountered in becoming and being a nurse entrepreneur.

**Methodology:** Two-round Delphi postal questionnaire; 4-point Likert scaling used to rate opinion statements. Purposive and snowballing sampling approach taken of 106 self-employed nurses recruited through the
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<td>Association of Nurses’ in Private Practice in Australia (now Nurses in Business). Pilot study undertaken in 10. First round included several statements related to influencing factors and entrepreneurial activities and included facility to garner suggestions for additional topics. Second round included a summary ranking of topics analysed in first round.</td>
<td><strong>Findings:</strong> Round 1 (n=59) and Round 2 (n=54). Important factors for private practice included: job satisfaction, being able to use distinctive skills, make a difference to patient care, enabled a return to nursing in line with other life activities. They did not enter into private practice because they were unemployable, unable to find work or redundant. Private practice offered a better proposal than hospital-based work and had the potential for increased income. Possessing previous experience and expertise was thought to be a prerequisite. Value was placed on autonomy, increased personal and work flexibility. Personal characteristics included: motivation, flexibility, creativity, willing to take a risk, independent nature without necessarily working alone, focus and vision.</td>
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**Background:** Entrepreneurial activities are those that create new options, involve some risk, require flexibility and are instigated as a result of motivation from those with entrepreneurial qualities. This enables nurses to consider private practice as a business development venture.

This second paper examines the scope of private practice roles within the Australian nursing profession, and assists in the development of additional ambulatory health services enabling the nursing profession to better understand one group of nurses and promote development of improved strategies to meet demands of health sector.

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Methodology: Data retrieved from Round two of Delphi Questionnaire (n=54 self-employed nurses recruited through Nurses in Business) which is divided into: socio-demographic, influencing decision-making factors, entrepreneurial qualities and scope of private practice.

Findings: Private practice nursing has come full circle from many years ago and a wide range of activities and clinical practice areas were identified. Primary entrepreneurial qualities included: ambition, assertion, accountability and commitment.

Entrepreneurship is not confined to private practice but it does enable nurses to remain within nursing when leaving acute-care sector.

Key difficulties include: building sufficient client base, remuneration issues, setting of suitable fees, referrals and recognition.

Background: Interest in non-standard working (NSW) has been growing over the past 20 years. As part of a larger project examining the changing dynamics of NZ labour markets, this study explores the unique area of case-loading midwives, particularly in self-employment. The concept of entrepreneurial capital is used to examine NSW in midwifery. These resources are described as belonging to 1 of 5 forms of capital – human, social, economic, physical and cultural – that eventually equal their total capital.

Aims: To explore the experiences of midwives in NSW from greater Auckland area and to expose the multi-faceted nature of entrepreneurial activities by highlighting the range of resources that entrepreneurs possess or acquire then employ when running a business.
**Reference**

self-employment.

*New Zealand College of Midwives Journal* 30: 6–10

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<td><strong>Methodology:</strong> Ethnographic study of 10 midwives using face to face interviews (6 were self-employed).</td>
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<td><strong>Findings:</strong> Case-loading midwifery is one form of self-employment and thus can be approached in business terms. Midwifery philosophy and practice can be conceived as the cultural capital of midwifery. Three broad outcomes include: provision of a detailed account of the mix of entrepreneurial capital unique to independent midwifery, gender dimensions of NSW and the importance of human, social, and cultural capital over financial and physical resources. Childbirth is viewed as normal healthy process and has as its central philosophy woman-centred care, partnership and continuity of care.</td>
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Addendum

This document was published by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) research programme, managed by the London School of Hygiene & Tropical Medicine.

The management of the Service Delivery and Organisation (SDO) programme has now transferred to the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton. Prior to April 2009, NETSCC had no involvement in the commissioning or production of this document and therefore we may not be able to comment on the background or technical detail of this document. Should you have any queries please contact sdo@southampton.ac.uk.